EXHIBIT 5

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF INDIANA
INDIANAPOLIS DIVISION

K.C., *et al*.,	)	
	)	
Plaintiffs,	)	
	)	
v.	)	No. 1:23-cv-00595-JPH-KMB
	)	
THE INDIVIDUAL MEMBERS OF THE MEDICAL LICENSING BOARD OF INDIANA, in their official capacities, *et al*.,	)	
	)	
Defendants.	)	

DECLARATION OF
KRISTOPHER KALIEBE, M.D.

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I, Kristopher Kaliebe, state as follows:

1. I am a medical doctor. I am trained in general psychiatry, child and adolescent psychiatry, and forensic psychiatry. My professional background, experience, and publications are detailed in my curriculum vitae, which is attached to this report.

2. I have been retained by counsel for Defendants in the above-captioned lawsuit to provide an expert opinion concerning care of patients with gender dysphoria and the need for open, scientific dialogue regarding how best to treat gender dysphoric youth. My opinion will be based primarily on my own experience as a physician, psychiatrist, and associate professor, as well as the relevant literature in this area. I have reviewed the expert reports of Dr. Daniel Shumer, Dr. Daniel Karasic, and Dr. Jack Turban. I have also reviewed the initial production of the Plaintiffs' medical records in this case, uncertified drafts of these physicians' depositions and that of Dr. Catherine Bast and Michelle Marquis. I may wish to supplement my opinions or the bases for them as new evidence comes to light or new research is published.

3. Over the past four years, I have testified at trial and/or deposition in the following cases:

a. Civil Testimony, retained by the defense:

i. In the Interest of RW, LL, AP Minor Children January 28, 2020 Circuit Court of the 13th judicial circuit, Juvenile Division, Judge Lisa Campbell, Tampa FL

ii. August Dekker et al. v. Simone Marstiller et al., Case No. 4:22-cv-00325-RH-MAF, U.S. District Court, Tallahassee FL, May 18, 2023

b. Civil Testimony:

i. February 28, 2020, Jeffrey Spivey, petitioner/father and Teresa Spivey N/K/A Teresa Cartwright, respondent/mother Case No.: 2016 DR0471's, Circuit Court of the 12th judicial circuit in and for Manatee County Florida. Judge Kevin Bruning

c. Civil Testimony, court appointed:

i. Re: The Marriage of Robyn Cohen McCarthy and John McCarthy, November 1, 2019 11th Judicial Circuit, Family Division, Dade County, Judge Jason Dimitris, Miami FL

d. Criminal Testimony, retained by the defense:

i. The State of Florida v. Bill Paul Marquardt, December 19, 2019 5th Judicial Circuit, Sumner County, Florida, Judge William Hallman III, Bushnell Florida

ii. The State of Florida v. Bill Paul Marquardt, August 24, 2022 5th Judicial Circuit, Sumner County, Florida, Judge Mary P. Hatcher Bushnell Florida

e. Civil Depositions, retained by the defense:

i. Z.M.L., a minor, through her parents and guardians, vs. D.R. Horton, Inc., a foreign corporation authorized to do business in Florida, United States District Court, Middle Division of Florida, Tampa, May 6, 2021

ii. The Estate of Jean Lindor, deceased minor, by and through the Personal Representative of the Estate, James Lacroix and Nouse Andree Lacroix, individually, Plaintiffs, v. Bos Transport, LLC, a Florida Limited Liability Company, and Orestes Zamora Fleites, individually, December 5th, 2022

iii. August Dekker et al. v. Simone Marstiller et al., Case No. 4:22-cv-00325-RH-MAF, U.S. District Court, Tallahassee FL, March 20, 2023

f. Civil Depositions, retained by the plaintiff:

i. Carlton Collins, individually, and on behalf of his minor son, Connor Samuel Collins v. David R. Wallace, Sr., M.D. Louisiana's 14th judicial district, Civil Suit: 2019 – 4128 – D, March 4th, 2022

g. Criminal Deposition, retained by the defense:

i. State of Florida v. Justin Mitchell Pennell, 2020CF000159FAXWS, 6th Judicial Circuit of the State of Florida in and for Pasco County, March 11, 2022

4. I am over the age of 19, am qualified to give this declaration, and have actual knowledge of the matters stated herein. If called to testify in this matter, I would testify truthfully and based on my expert opinion. I am being compensated at a rate of $400 per hour. My compensation does not depend on the outcome of this litigation, the opinions I express, or the testimony that I provide.

BACKGROUND AND QUALIFICATIONS

5. I am an associate professor at the University of South Florida in Tampa, Florida. I was recently promoted to full professor, active July 1, 2023. I am Board Certified in Psychiatry, Child and Adolescent Psychiatry, and Forensic Psychiatry. My clinical work has been primarily in university-based clinics, Federally Qualified Health Centers, and juvenile corrections.

6. I was awarded my medical degree in 1999 and subsequently completed general psychiatry, child and adolescent psychiatry, and forensic psychiatry training. This training includes

education in human biology, human sexuality, development, brain functioning, normal development, and psychopathology. Gender dysphoria and gender dysphoria treatment were part of my professional training.

7. From 2005 to 2016, I was Assistant Professor at Louisiana State University Health Science Center – New Orleans. I was the program director of the LSU Child Psychiatry Fellowship for 2 years. Since 2016, I have been Associate Professor at the University of South Florida, where my clinical roles mainly include working with juvenile corrections and supporting primary care physicians through the Florida Medicaid Psychiatric Medication hotline. I serve in an on-call capacity at Tampa General Hospital. I also practice forensic psychiatry, working on both child and adult cases in both criminal and civil court.

8. In addition, I work in two university-based training clinics. For my entire stay at the University of South Florida I have supervised a child and adolescent psychiatry clinic, and I recently added an adult psychiatry resident clinic to my schedule.

9. As a supervising physician at the University of South Florida's Silver Child Development Center, my role is to function as a clinical supervisor and instructor. Child psychiatry residents and general psychiatry residents serve as the primary patient evaluators and clinicians. I also evaluate new patients directly and then see patients as needed. I oversee the residents' work product and function as the physician of record. In this clinic I evaluate and treat pediatric patients with gender dysphoria. In addition to these direct clinical experiences, my duties at the Silver Child Development Center include training residents regarding the treatment of patients, including those with gender dysphoria.

10. Similarly, at the University of South Florida's Outpatient Psychiatry Center, my duties include supervising and instructing psychiatry residents. At this clinic as well, general psychiatry residents serve as the primary patient evaluators and clinicians, and I evaluate new patients directly and see them afterward as needed. I oversee the residents' work product and function as the physician of record. As part of my role in this clinic, I evaluate and treat patients with gender dysphoria.

11. Within the juvenile justice system, I also evaluate and treat patients with gender dysphoria. And I have been consulted to provide a second opinion and coordinate care regarding a patient with gender dysphoria in the Louisiana juvenile correctional system.

12. In addition to direct clinical care, I am routinely consulted by colleagues. For instance, I have provided an opinion on whether a pediatric patient was competent to assent to the administration of puberty blockers to enter on a path toward sex hormone treatment and potential surgeries. I have also been consulted regarding psychotherapeutic approaches to young adult patients who detransitioned. And I have collaborated in the care of patients with gender dysphoria as part of my work with the Florida Medicaid Psychiatric Hotline.

13. I have extensive teaching experience, including teaching medical students, general psychiatry residents, child and adolescent psychiatry fellows, and forensic psychiatry fellows. I have years of extensive positive feedback from medical students and psychiatrist residents.

14. I practice and support conventional medicine, and I have also strongly advocated for the expansion of Federally Qualified Health Centers, along with improved collaboration of mental health with primary care (Kaliebe 2016, Kaliebe 2017).

15. My support of, and attempts to improve conventional medicine, are balanced by a healthy degree of caution. The history of medicine is filled with examples of the harms that can

come with unproven, unnecessary, aggressive, or counterproductive interventions. As such, I have presented twice at the Preventing Overdiagnosis Conference.

16. Another clinically relevant academic interest of mine is the tradeoffs and influence of technology and mass media, especially on young people. (Kaliebe 2002, Gerwin 2018). I have long focused on how technology and the media intersect with society and culture, including the impacts of social media, recent increases in tribalism, and the spread of misinformation. With Paul Weigle, I co-edited the Child and Adolescent Psychiatric Clinics of North America *Youth Internet Habits and Mental Health* edition in 2018. This compilation of clinical review articles included 16 chapters by invited experts on digital and mental health related issues. (Kaliebe 2018). I presented on distraction and misinformation at the 2022 conference of the American Academy of Child and Adolescent Psychiatry.

17. I am a member of the American Academy of Child and Adolescent Psychiatry, the American Academy of Psychiatry and the Law, and the American Psychiatric Association. I have been most active in the American Academy of Child and Adolescent Psychiatry (AACAP). I was awarded status as a Distinguished Fellow at AACAP in 2016. I first presented regarding media at the 2004 AACAP annual conference and have now presented at the annual conference 25 times. I served as co-chair of the Media Committee from 2013-2021 and was an author on the AACAP's clinical practice guidelines for telepsychiatry. I served as the Liaison from AACAP to the American Academy of Pediatrics from 2016-2022. I have also served AACAP in the state affiliates, acting as the Louisiana Council for Child Psychiatry as secretary/treasurer for 4 years and as president for 2 years.

18. I have extensive experience in psychotherapy and have received additional training in Cognitive Behavioral Therapy and trauma-focused therapies. I have been providing psychotherapy and teaching psychotherapy to psychiatry trainees throughout my career. I currently routinely supervise psychiatry residents at USF regarding psychotherapy. I created and taught a Cognitive Behavioral Therapy practicum for LSU residents from 2007 to 2016. I was a member of the Association for Behavioral and Cognitive Therapies from 2004 to 2016.

SUMMARY OF MAIN POINTS

19. While historical reports of gender dysphoria exist, they were rare until approximately the last decade. Since then, the number of youth suffering from gender dysphoria has skyrocketed across countries in the economically advanced Western world.

20. Significant evidence connects the recent increase in gender dysphoria to a spread of ideology combined with technologically induced contagion effects.

21. Small numbers of advocate physicians within medical organizations have been able to leverage moralized claims and low-quality evidence to promote medical interventions for gender dysphoria in minors.

22. As American medical professional organizations have already endorsed the concept of so-called affirmative care as evidence-based and ethical, they are no longer neutral with regard to the science and have instead entered advocacy roles.

23. The language and assumptions supporting affirmative care for gender dysphoria are often based upon conjecture, opinion, or misinformation presented as established fact.

24. Due to the highly politicized and ideological nature of the issue of gender dysphoria, and efforts by proponents to silence debate, there is limited rigorous scholarly dialogue within American professional medical organizations and medical journals.

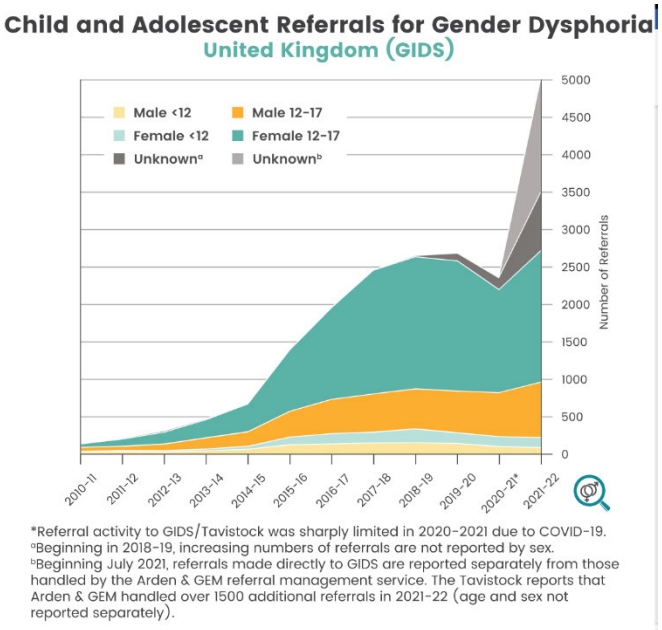
THE RECENT RISE IN TRANSGENDER AND NON-BINARY IDENTIFICATION AMONG YOUNG PEOPLE

25. Current discussions regarding transgender care take place in the context of an unexplained and remarkable rise in minor patients reporting gender dysphoria. During my medical school experience and three residencies, I never encountered a patient reporting symptoms of gender dysphoria. For eleven years, from 2005 to 2016, I had a busy psychiatry clinic composed of roughly 80% minors and 20% adult patients. Not a single patient presented with gender dysphoria.

26. During those eleven years, none of the hundreds of medical students or residents I supervised presented cases to me describing patients with gender dysphoria. None of my social work or psychologist colleagues ever asked for consultation or advice regarding how to clinically approach patients with gender dysphoria.

27. By contrast, on a single day in the last year, I treated three adolescent patients who had been diagnosed with gender dysphoria.

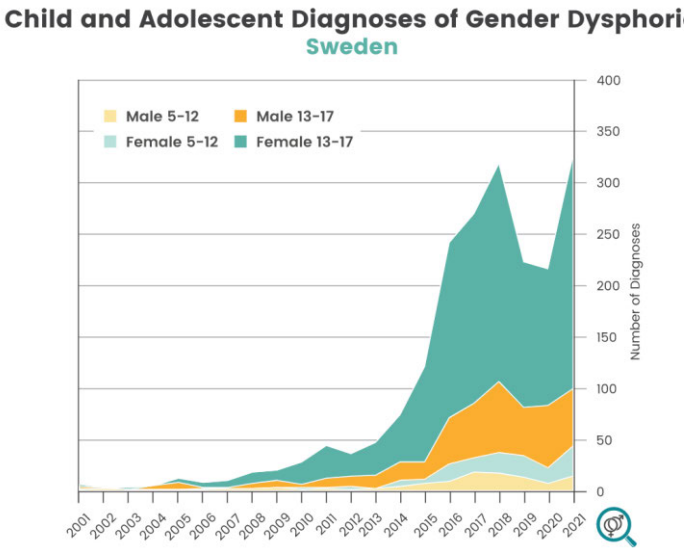
28. My experience is consistent with statistics indicating an abrupt rise in gender dysphoria and presentations to medical clinics for related services. While the exact number is unknown, it can be said that the incidence of gender dysphoria in youth was previously rare. The American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders published in 2013 rated in adults at 2-14 per 100,000 (American Psychiatric Association p. 454). Referrals at the Tavistock clinic in England increased over



50-fold in just a decade from 2009 to 2019. (Tavistock & Portman, NAHS Foundation Trust, 2020).[1]

29. Similar increases have been reported across much of the economically advanced countries in the world, many showing an over 1000% rise in gender dysphoria over the last decade (Marianowicz-Szczygiel 2022).

30. Never before have there been large cohorts of individuals seeking medical services to alter their secondary sex characteristics. There have been decades of extremely rare treatment which was at the time acknowledged as compassionate but experimental care. Yet the current patients expressing gender dysphoria represent primarily a new and distinct patient population, not a population which has historically existed. As the independent review of the gender identity services for children and young people in the UK noted, the sudden "increase in referrals has been accompanied by a change in the case-mix from predominately birth-registered males presenting with gender incongruence from an early age, to predominately birth-registered females presenting with later onset of reported gender incongruence in early teen years." (Cass 2022).



Incidence data for 2001-2018 from the Swedish National Board of Health and Welfare[a] were applied to population counts by age/sex/year from Statistics Sweden[b] to produce estimated GD diagnosis counts. Incidence data for 2019-2021 were drawn from an update of "God vård av barn och ungdomar med könsdysfori, 2015" (Socialstyrelsen, 2022, unpublished).
[a]Socialstyrelsen, Utvecklingen av diagnosen könsdysfori - förekomst, samtidiga psykiatriska diagnoser och dödlighet i suicid, 2020.
[b]https://www.statistikdatabasen.scb.se/pxweb/en/ssd/START__BE__BE0101__BE0101A/BefolkningR1860N/

[1] Graphs were created by the Society for Evidence Based Gender Medicine and were drawn from data by the Tavistock clinic and the Swedish National Board of Health and Welfare, respectively.

31. As a psychiatrist, I have encountered many patients who are uncomfortable with their bodies. This discomfort or dissatisfaction is often comingled with anxiety and depression, along with various diagnoses which involve bodily discomfort, including eating disorders or Body Dysmorphic Disorder.

32. I have observed bodily discomfort more often in females, especially as girls enter puberty, which is consistent with the epidemiological literature. Puberty introduces significant challenges and risks to females as they receive more attention from males, including adult males, along with increased competition from peers. Puberty now comes much younger than for our ancestors, creating a greater mismatch between brain and body maturity.

33. When a new patient population emerges, as it has with minors suffering from gender dysphoria, it creates challenges for physicians to respond. This phenomenon requires some explanation, and any complex phenomenon likely has a multifactorial line of causation. Yet multiple lines of evidence point to direct social influences and online and social media contagion as major contributors to the remarkable rise in gender dysphoria in adolescents.

34. The influence of culture, medical theories, and ideology on symptom production is long-standing and well known. Numerous examples of how culture has intersected with psychiatric illness from the Victorian to modern era have been detailed in the literature (Shorter 1993). The mere act of codifying a psychiatric disorder can cause a new clinical presentation among those with pre-existing mental health challenges (Gauld 2022; Horesh 2022).

35. The development of new treatments can also usher forth changes in symptom production, change patient presentations, and increase requests for treatment at medical or mental health clinics. Peter's Kramer's 1993 "Listening to Prozac" spent 21 weeks on the New York Times Best Seller list. Prozac (trade name fluoxetine) ushered in what can be termed cosmetic

psychopharmacology, the hope of making patients "better than well." (Kramer 1994). Marketing for fluoxetine included selling the concept of depression as a medical disorder. More patients showed up in clinics wanting treatment as other serotonin reuptake inhibitors joined the market. Just naming these substances "anti-depressants" was a smart trick of language to increase patient expectations. Fluoxetine remains a useful medicine, yet no longer are attitudes about fluoxetine celebratory: much of what initially seemed a strong response was placebo, and long term results were much less impressive than what was seen in short term studies. (Oronowicz-Jaśkowiak, 2019). The modern era of psychopharmacology altered individuals' views of themselves and what about themselves they desire to change, but the medicalization of mood through psychopharmacology has not ushered in an era of improved mental health and flourishing.

36. Humans evolved as a sexually dimorphic, ultra-social, and cultural species. Culture has comingled with our evolution because learning from others enables our very survival. Humans acquire a considerable portion of our behaviors and viewpoints "by tapping into a large body of non-genetic information that has been filtered and accumulated over generations. This process, termed cumulative cultural evolution, creates a storehouse in the form of strategies, attentional biases, motivations, tastes, and cognitive heuristics that are necessary for us to accomplish even the basics of survival." (Henrich 2021, p. 210).

37. Humans thus cannot explain the original rationale for many of our routines, habits, and customs because they have been shaped over time. Cumulative culture constantly changes, but the recent rate of change has been exponentially faster due to the explosion of technologies. The modern world is thus experiencing perhaps the largest generation gap in history, much of which is caused by media and online experiences.

38. In ancient evolutionary environments, copying others aided survival via the transmission of acquired knowledge about which areas were safe, how to make shelters or weapons, which berries or mushrooms were safe to eat, and what type of social behavior was acceptable within a group. Human brains are particularly adapted with exceptional abilities to notice and copy the behavior of others, and transmission of culture occurs in part via humans' naturally mimicking what we observe in others.

39. Unfortunately, these same instincts that develop helpful behavioral norms also enable social contagions that comingle with mental and behavioral disorders. Long-standing scholarly consensus exists confirming that direct social contagion not only affects health, such as cardiac disease (Christakis 2013), but interacts with technology to enable the spread of mental health problems (Haltigan 2023). For instance, in recent years technology has aided the spread of suicide contagion (Yildiz 2019), non-suicidal self-injury (Jarvi 2013), and contagion related to eating disorders such as anorexia (Allison 2014).

40. Since the COVID-19 pandemic, there has been an explosive increase of young people displaying features of Dissociative Identity Disorder (Gauld 2022) and movements similar to those seen in Tic Disorders such as Tourette's (Pringsheim 2021). Similar to other examples of social contagion, these sudden onset tic presentations tend to be comorbid with pre-existing mental illnesses, and adolescent girls show themselves to be the most susceptible.

41. The phenomenon labeled Mass Social Media Induced Illness (Giedinghagen, 2022) shows us that, at scale, users of social media can develop technology-facilitated psychosomatic illness. Psychiatrists have seen an abrupt rise in patients presenting with a social media enabled self-diagnosis (Rettew 2022, Weigle 2023).

42. Similarly, significant evidence suggests that the dramatic rise in minors presenting with gender dysphoria may be attributable to technologically induced contagion effects. In 2018, researcher Lisa Littman conducted a survey of parents of gender dysphoric youth whose gender dysphoria began during or after puberty (Littman 2018). "Most (86.7%) of the parents reported that, along with the sudden or rapid onset of gender dysphoria, their child either had an increase in their social media/internet use, belonged to a friend group in which one or multiple friends became transgender-identified during a similar time-frame, or both." (Littman 2018 p.2) Littman thus hypothesized that, as with other social contagions such as disordered eating, aggression, bullying, and drug use, "it is plausible that the following can be initiated, magnified, spread, and maintained via the mechanisms of social and peer contagion: (1) the *belief* that non-specific symptoms (including the symptoms associated with trauma, symptoms of psychiatric problems, and symptoms that are part of normal puberty) should be perceived as gender dysphoria and their presence as proof of being transgender; (2) the *belief* that the only path to happiness is transition; and (3) the *belief* that anyone who disagrees with the self-assessment of being transgender or the plan for transition is transphobic, abusive, and should be cut out of one's life." (Littman 2018 p. 33)

43. As explained below, Littman's paper and her hypothesis of a "rapid-onset gender dysphoria" received remarkable blowback from advocates of "gender affirming care." The journal that published the paper retracted the initial paper, issued a "correction," and re-published the paper (with the initial data unchanged). Since then, the hypothesis of a social contagion element to adolescent gender dysphoria has only grown stronger.

44. Clinicians working at the Tavistock clinic in London (before its closure, the world's largest adolescent gender clinic) expressed support for Dr. Littman's concept of Rapid Onset Gender Dysphoria: "While some of us have informally tended toward describing the phenomenon we

witness as 'adolescent-onset' gender dysphoria, that is, without any notable symptom history prior to or during the early stages of puberty (certainly nothing of clinical significance), Littman's description resonates with our clinical experiences from within the consulting room" (Hutchinson 2019). They added: "[I]t is commonplace for clinicians to engage in conversations regarding this phenomenon. Furthermore, from speaking with international colleagues, it seems to us that this phenomenon is also being observed in North America, Australia, and the rest of Europe."

45. Littman's research and her conclusions should not have surprised those following the literature on gender dysphoria. Three years earlier, a leading Finnish clinician (Kaltiala-Heino, 2015) showed that a new cohort, mostly females with significant emotional disturbance, was presenting to gender clinics: "It is important to be aware of the different groups, or developmental pathways, in gender dysphoric adolescents in order to be able to find appropriate treatment options. In the presence of severe psychopathology and developmental difficulties, medical [sex reassignment] treatments may not be currently advisable. Treatment guidelines need to be reviewed extended to appreciate the complex situations." In other words, three years *prior* to Littman's work, researchers had already identified the new cohort of patients Littman later wrote about: "In our data, most of the adolescents first presented with gender dysphoria and cross-gender identification well after the onset of puberty, and the vast majority suffered significant psychopathology and broader identity confusion than gender identity issues alone. It is important to be able to openly discuss these alternative presentations of gender dysphoria in order to find appropriate treatment options." The UK Cass Review recently came to a similar conclusion: "At present we have the least information for the largest group of patients—birth-registered females first presenting in early teen years." (Cass 2022 p.58).

46. A recent paper (Diaz 2023) analyzed survey results of parents of children who believe their children to have Rapid Onset Gender Dysphoria. This survey found a large portion of natal males with prior onset of video game addiction (17%), and substantial numbers of these youth were reported to have internet addiction (14% for natal males and 16% for natal females) prior to gender dysphoria. The paper concluded: "Youths with a history of mental health issues were especially likely to have taken steps to socially and medically transition…. parents believed gender clinicians and clinics pressured the families toward transition. The finding is particularly concerning given that parents tended to rate their children as worse off after transition."

47. Dr. Jack Turban, a psychiatrist and transgender activist, recently attempted to argue against social influences on gender dysphoria and transgender status, warning that "the notion of ROGD has been used in recent legislative debates to argue for and subsequently enact policies that prohibit gender-affirming medical care for [transgender and gender diverse] adolescents." As is often the case when activism is prioritized over scholarship, Dr. Turban's article is replete with misinformation. The article begins by asserting, for instance, that the ROGD "hypothesis was formed solely through the analysis of online parental survey data." (Turban 2022). But as shown above, clinicians had already reported the change in patient profile three years *before* Littman's article, in 2015.

48. Even more significantly, a letter to the editor published in *Pediatrics* noted that Turban's article contained "critical theoretical and methodological concerns specific to its conceptualization of social contagion and its data analysis." (Lett 2022). Much more substantial critiques were rejected by the editors at *Pediatrics*; while not searchable or indexed as scholarly work, some of the critiques are available as comments on the article's web page. One group of authors, led by Leonora Regenstreif at McMaster University (home of evidence-based medicine), documented

concerns about "the non-random sampling," "the information not solicited in the survey, the wording and possible interpretations of the questions, as well as the accuracy and completeness of the data generated… [and] the imprecise wording of several questions regarding self-identity and sexuality." (Regenstrief 2022.) This group noted how Turban "assume[d] away" the key question of how trans-identified teens will answer "What is your sex?", even though the CDC had "urg[ed] caution in interpreting the 'sex' variable" because it is known that some trans-identified teens will give their *gender* rather than their biological sex when asked for their sex. Yet Turban's entire study was based on this assumption. (Regenstreif 2022). Another researcher ran the data and found out that, indeed, transgender respondents who identified as male were on average 2.5 cm shorter than non-transgender male respondents, indicating "that some of the transgender respondents who identified themselves as male were natal females." (Biggs 2022A). As that researcher concluded: "Given the ambiguity of the [survey's] question on sex—evidently confusing to respondents and to scientists alike—no conclusion about the sex ratio of transgender youth can be drawn from this survey. The article does, however, provide considerable insight into the editorial standards maintained by *Pediatrics*." (Biggs 2022A). To add precision to Biggs' point, the problem is not general lax editorial standards at Pediatrics, but low standard specifically observed in gender medicine.

49. Regarding social contagion and Rapid Onset Gender Dysphoria, Turban also reported in that same article that he is attempting to influence political and legislative actions. He theorizes that scholarly discussion of the data supporting the social influence hypothesis is somehow harmful. He lamented: "The deleterious effect of unfounded hypotheses stigmatizing [transgender and gender diverse] youth, particularly the ROGD hypothesis, cannot be overstated, especially in current and longstanding public policy debates." (Turban 2022). This statement alone

reveals that Turban in fact is willing to overstate, thereby prioritizing advocacy over science and the search for the truth.

50. Whereas "gender affirming" organizations like WPATH have been critical of the "rapid-onset gender dysphoria" hypothesis and the possibility of a social element to the rise in cases of adolescent gender dysphoria, healthcare authorities in other countries have paid more attention. As already noted, the independent Cass Review in the UK has recognized the rapid change in patient profile and warned that little data exists "on the more recent case-mix of predominately birth-registered females presenting in early teens" because "[m]uch of the existing literature about natural history and treatment outcomes for gender dysphoria in childhood is based on a case-mix of predominately birth-registered males presenting in early childhood." (Cass 2022 p.19).

51. Likewise, last February the French National Academy of Medicine noted: "Whatever the mechanisms involved in the adolescent—overuse of social networks, greater social acceptability, or example in the entourage—this epidemic-like phenomenon results in the appearance of cases or even clusters in the immediate surroundings." It recommended "[t]he vigilance of parents in response to their children's questions on transidentity or their malaise, underlining the addictive character of excessive consultation of social networks which is both harmful to the psychological development of young people and responsible, for a very important part, of the growing sense of gender incongruence."

52. In my experience, many psychiatrists in America also believe social media has significantly contributed to the rise in gender dysphoria. Yet most child and adolescent psychiatrists I speak with admit to me that they will not speak publicly on this subject due to how sensitive the

topic is, expressing fears of hostilities from activists along with condemnation and retribution from others within their universities or organizations.

53. My personal conversations align with recent polling. As part of the Social Media Institute at the October 2022 American Academy of Child and Adolescent Psychiatry annual conference, program chair Paul Weigle anonymously polled the audience on a number of topics. When polled: "How often do you see teens who seem to be influenced by social media in regards to their sexual and/or gender identity?", 80 of 97 (82%) of the child psychiatrists in attendance indicated social media was an influence "somewhat often" or "very often." This data was recently published in *Psychiatric Times* (Weigle 2023), and to my knowledge, is the first data suggesting that the vast majority of a group of child and adolescent psychiatrists acknowledge that social contagion may be a major contributor to the rise in gender dysphoria.

54. A similar poll was conducted by Dr. Weigle at the January 18, 2023, meeting of the Child & Adolescent Psychiatry Society of Greater Washington, where all attendees were physician members. When asked, "How often do you see teens who seem to be influenced by social media in regards to their sexual and/or gender identity?", there were 34 respondents. 47% indicated *Occasionally* and 35% indicated *Often*. So again, 82% of these child and adolescent psychiatrists reported that they see teens' gender identity being influenced by social media. These polls suggest that practicing child and adolescent psychiatrists have direct clinical experience leading them to believe social media is influencing gender identity in their patients. More research is needed into Rapid Onset Gender Dysphoria and other possible causes of the recent change in patient profile in gender dysphoric youth.

55. In my opinion, technological, ideological, and social factors underlie much of the recent increase in gender dysphoria in adolescents. While this does not rule out other factors, the

ongoing research demonstrating an association between ideology, social factors and gender dysphoria in adolescents raises serious doubts about the wisdom of using transitioning treatments like puberty blockers and cross-sex hormones to treat the new population of gender dysphoric youth.

THE DANGERS OF PROCLAIMING A FALSE SCIENTIFIC CONSENSUS FOR HOW BEST TO TREAT GENDER DYSPHORIC YOUNG PEOPLE

A. Best Practices for Scientific Dialogue

56. Our highly social nature and limited rationality demand that, in medicine and science, we create conditions which foster trustworthy data and minimize the creation and spread of misinformation. In my opinion, medical organizations and journals have recently prioritized advocacy over science when it comes to considering treatments for gender dysphoric young people.

57. Evidence based medicine requires "the development and promotion of a universal set of scientific rules that ensure accurate inferences on the basis of experience" (Djulbegovic, 2009). A prescription for open exchange and deliberate consideration regarding gender dysphoria treatments should aspire to:

a. Solicit a diversity of perspectives.

b. Discuss the argument, rather than the person making the argument.

c. Clarify the methods, source of data and its limitations.

d. Use precise language rather than broad ideologies.

e. Discuss potential sources of bias, including those related to group affiliation.

f. Quickly acknowledge and correct mistakes.

58. This framework would depersonalize the search for truth and esteem empirical dialogue, which has been in short supply on numerous topics within academia. (Haidt 2020).

59. For this reason, clinical practice guidelines and documents providing generalized medical recommendations must objectively reflect the evidence base. The *Mayo Clinic Proceedings* article, "Clinical Practice Guidelines: A Primer on Development and Dissemination," (Murad 2017) highlights that "trustworthy clinical practice guidelines require a systematic review to select the best available evidence and should explicitly evaluate the quality of evidence." The authors argue that trustworthy guidelines should:

a. "Be based on explicit and transparent process that minimizes distortions, biases and conflicts of interest."

b. "Provide a clear explanation of the logical relationships between alternative care options and health outcomes."

c. "Provide ratings of the quality of evidence and the strength of the recommendations."

B. How Breakdowns in Scientific Dialogue Occur

60. Ideological homogeneity and group identity are risk factors for developing irrational beliefs and spreading misinformation. (Sun 2022; Macy 2018). This directly relates to attitudes about transgenderism and gender dysphoria treatments where ideological dogma has distorted scientific exploration. Those who dare to question the dogma, such as Littman, are treated as heretics.

61. The dynamics of this polarization and lack of intellectual humility are understandable. Within psychiatry and medicine, practitioners face patients afflicted by enormous suffering. Gender non-conforming patients at times face harassment and discrimination. Patients expressing gender dysphoria have high rates of depression, anxiety, and self-harm. All physicians and mental health professionals want to help. Those who started adolescent gender clinics hoped to relieve

suffering. Yet in medicine excessive optimism regarding low quality treatments can exacerbate rather than reduce suffering.

62. All humans, including physicians, tend to find arguments in favor of conclusions we want to believe. This bias is known as motivated reasoning (Peters 2020). Supporters of gender-affirming treatment want to believe they have found an ethical and evidence-based solution. This motivated reasoning explains the strong divergence between the enthusiastic support for gender-affirming treatments and their relatively weak evidence base (Brignardello-Peterson 2022).

63. Once a group, such as a gender committee, endorses a statement of belief, such as "gender affirmative care is life-saving," other psychiatrists in their professional organization who have not reviewed the facts tend not to question it. Psychiatrists face a rapidly expanding evidence base across disorders, and we depend on specialization to lead us toward progress in our varied patient populations.

64. Especially if the "experts" assert a strong moral claim regarding a clinical approach, other physicians would assume it is based on strong evidence. This creates a group process where the leadership responds to show support and loyalty, and others tend to follow. Support of this moral claim becomes a marker of virtue and raises status within the group. Those who are skeptical tend to self-censor (a "spiral of silence") rather than taking a risk of being called unethical (Noelle-Neumann 1974). These dynamics, especially leadership's endorsement, make opinions appear like facts within the group. Members of this group never hear counterarguments or disconfirming data and become ever more confident.

65. Within such moralized environments, education and intelligence offer limited protection from irrational beliefs. In fact, sophisticated language skills enable virtuosity in creating

and promoting false narratives. These dynamics have arisen before in medicine, and it is my assessment this has occurred again with regards to medical interventions to treat gender dysphoria in minors.

66. Contrary to popular belief, humans' emotional programing drives much of our cognitive processes. That is, we tend to create beliefs that go along with what we feel, rather than the other way around. This usually works well, but also causes serious problems. In cognitive therapy, it is known as "emotional reasoning." Emotional reasoning helps explain opinion cascades, partisanship, and group-think, as those who identify strongly with a group tend to feel positively toward those in the group and negatively toward the out-group.

67. The moralized framing of affirmative treatments for gender dysphoria encourages a cognitive shortcut known as attribution substitution (Sunstein 2009, p. 216). Attribution substitution is the process whereby a simple, related moral judgement is substituted for various conceptually complex decisions. This common cognitive bias causes humans to intuitively believe viewpoints which appear virtuous, especially ideas which seem widely held within their social group. "Affirmative care" sounds compassionate and supportive, and these minor semantics can have a surprising influence.

68. Physicians can be especially susceptible to manipulation. Psychiatrist Anna Lembke, in her 2016 book *Drug Dealer, MD: How Doctors Were Duped, Patients Got Hooked, and Why It's So Hard to Stop*, explained that "[d]octors are by and large pleasers" because "[t]hey make it through the complex maze of schooling all the way to medical school by figuring out early what people want and providing it." (Lembke 2016, p. 104). In this way, physicians are susceptible to acquiesce to patient narratives and overtreat.

69. Conditions resting on entirely subjective assessments like level of pain or gender identity have the most potential for harmful overtreatment. In both cases, patients can easily find out what symptoms to report to obtain the treatment they desire, as has been noted in the Cass Interim Review: "We have heard that some young people learn through peers and social media what they should and should not say to therapy staff in order to access hormone treatment." (Cass Review 2022). In the current political climate, physicians feel the pressure to not be assailed as "gatekeepers," even when logic and data tell them that outside social pressures should not distort medical care.

C. Historical Examples of Harmful Scientific "Consensus" and Overtreatment

70. The medical system has a long history of spurts of overdiagnosis and overtreatment. Oncologist Otis Brawley laments that "our medical system fails to provide care when it is needed and fails to stop expensive, often unnecessary, and frequently harmful interventions even in situations when science proves these interventions are wrongheaded" (Bawley 2011, p. 22). Many of our harmful interventions such as frontal lobotomies were celebrated at the time. Eventually society sees the harm, pushes back, and the medical profession eventually reforms.

71. Hydrotherapy, sterilization, lobotomy, and clitoridectomy (removal of clitoris to treat "hysteria") were each a part of the medical establishment in the first half of the twentieth century (Braslow 1997). Prior to the age of antibiotics, neurosyphilis was a common cause of psychiatric admission, diagnosed at that time as general paralysis of the insane. The causative theory was the premature using up of cerebral vitality through excessive enjoyment of wine, women, and life. A common treatment of the time was malarial induced fever. It was thought this "treatment" saved patients from general paralysis of the insane, which had a fatal course (Shaw 1927).

72. For decades, sterilization was legitimized by the medical establishment. Not long ago, "[t]he most important elite advocating eugenic sterilization was the medical establishment," which advocated "with near unanimity" for the procedure. "[E]very article on the subject of eugenic sterilization published in a medical journal between 1899 and 1912 endorsed the practice." (Cohen 2016).

73. Similarly, pioneers of frontal lobotomies spun their procedure with enthusiastic endorsement of the therapeutic nature of the procedure, ignoring evidence to the contrary. Their overstatements propelled lobotomies to gain acceptance among physicians desperate for new tools to address clinically challenging patients (Afkhami 2022). When the developer of the lobotomy, António Moniz, won the Nobel Prize in 1949, it further legitimized the operation. Even in 1954, the American surgeon and proponent of the surgery Walter Freeman claimed that transorbital lobotomies had mortality and morbidity rates that were "gratifyingly and consistently low" (Afkhami 2022). Yet by this time, medical journals were already documenting harms done (Afkhami 2022). Afkhami et al.'s linguistic analysis displays how lobotomy proponents projected a sense of heroism. They showed confirmation bias, i.e., these advocates ignored evidence disconfirming their theories. They tracked onto social norms in order to aggrandize their treatments and create a moral imperative to use lobotomies; as Freeman argued in 1954, "it seems not only possible, but obligatory, to extend the program of psychosurgery into the state mental hospitals in an effort to relieve human misery" (Afkhami 2022).

74. Medical educators teach residents and students when reviewing research to look for bias. Who initiated this research? Did they have a certain goal or outcome in mind, or are they neutral? This is because when advocates or industries fund research, multiple mechanisms cause the research typically to obtain the result desired by the funders. (Sismondo 2008). Within my

career, I witnessed the pharmaceutical industries' manipulations to promote antidepressants. These manipulations were aided by our professional organizations, such as the American Psychiatric Association and American Academy of Child and Adolescent Psychiatry, who at the time were receiving significant funding from industry. "It's possible for good people, in perversely designed systems, to casually perpetuate acts of great harm on strangers, sometimes without ever realizing it" (Goldachre 2014, p. xi). In the 2000s, an audit found that over 90% of the psychiatrists who created the clinical practice treatment guidelines were also paid by the pharmaceutical industry (Cosgrove 2009). Not surprisingly, the treatment guidelines at the time were overly focused on medications and downplayed other approaches. At psychiatric meetings and in our medical journals, those of us whose approach went beyond medications were marginalized.

75. It was only after being sued that pharmaceutical companies were forced to release all their data, revealing that overall antidepressants often do not beat placebo, especially when treating children and adolescents. After this embarrassment, in the late 2000s, the American Psychiatric Association and American Academy of Child and Adolescent Psychiatry put in reforms to limit undue influence of pharmaceutical companies. In part, overtreatment occurred at scale because providers were fooled by their clinical experience, as antidepressants have such a strong placebo response. In fact, it now appears that four out of five positive responses are arguably a placebo response (McCormack 2018, Hopcroft 2018, Oronowicz-Jaśkowiak, 2019).

76. For years, when antidepressant medications research obtained unfavorable or neutral results, these results were often never submitted for publication or buried in an obscure journal. (Turner 2008). Unfavorable results of antidepressant trials were also significantly delayed, known as "time lag bias" (Reyes 2011). Positive antidepressant trials were typically published quickly and in prestigious journals; thus, psychiatrists following the published literature were falsely led

to believe, for many years, that medications like paroxetine (Paxil) effectively treat depression in children. We now know, after the complete set of research has been released, that for children, many medications, including paroxetine, do not beat placebo. This is all the more concerning as psychiatrists and other providers exposed thousands of young people to paroxetine's side effects, which include increased suicidality. Publication bias in medical journals distorted medical dialogue and led to mass adoption of ineffective and potentially damaging treatment. It was not only financial incentives that led to harm, but also doctors' egos, observations of placebo effects, and desires to relieve suffering. We thus must remain skeptical, and aware that negative results tend to be buried and positive results tend to be published. Notice the Tavistock failed attempt to replicate the Dutch study was never published in a peer review journal. This is evidence of likely publication bias in gender medicine and suggests that even following peer reviewed journals can steer clinicians toward harmful treatments.

77. Within psychiatry and mental health, we have seen waves of theories. Psychoanalysis no longer dominates psychiatry but serves as an example of how a non-empirical, theoretical approach can gather support, become dominant, and enforce ideological hegemony within psychiatry. When I was a trainee, many psychiatric leaders were trained as psychoanalysts, and it was clear that it was not socially acceptable for trainees to challenge the psychoanalytic orthodoxies. An anthropologist even documented our psychiatric sub-cultures and how we are "of two minds" (Luhrmann 2001). For decades, psychoanalysis dominated American psychiatry. "By 1960, virtually every major psychiatry position in the U.S. was occupied by a psychoanalyst. More than half of all psychiatrists were training to become analysts or were analytically-inclined in their orientation. All of the major psychiatry departments appointed psychoanalysts as chairmen." (Rufalo 2019). Furthermore, psychiatrists "seemed more interested in becoming respected members of the

establishment than in challenging it. Insular, highly competitive, and prestigious, psychoanalysis became a 'status symbol.'" Psychoanalysis rose to and maintained dominance for decades not because it was effective at treating mental illness but because it served as a marker of intellectual sophistication and membership in the leadership class. It is my opinion that these same dynamics have led to the over-enthusiastic support for affirmative treatments for gender dysphoria among psychiatrists.

78. The repressed and false memories movement of the 1980s and 1990s is another example of wide adoption of a theory without adequate evidence. While human memory is indeed flawed, and reports of distant memories being retrieved cannot be uniformly ruled as false, we know, and should have also known at the time, that human memory is susceptible to manipulations and is frequently inaccurate. A large contingent of mental health practitioners displayed a lack of skepticism, which led to harms both to patients and to those who were at times falsely accused. (Otgaar 2022).

79. The recent opioid epidemic is medicine's most recent and deadly episode of overtreatment. Harmful and unnecessary interventions are especially likely to occur when patient desires are combined with financial incentives and the best of intentions. The American opioid epidemic was ushered in by "expert" physicians who proposed that physicians needed more compassion because "pain is the 5th vital sign" (Mandell 2016, Adams 2016). Advocates for this approach were able to convince administrators and hospitals to push "improvements" in clinical care which prioritize documenting and reducing pain, with the result that opioid prescriptions skyrocketed. While a small number of patients may have achieved better pain control as a result, it came at the cost of creating legions of addicts. The Veterans Health Administration launched the "Pain as the

5th Vital Sign" initiative in 1999, requiring a pain intensity rating (0 to 10) at all clinical encounters. In 2001, the Joint Commission on Accreditation of Health Care Organizations warned that it would be looking at organizations' pain assessments in their accreditation judgments, thus using government fiat to force health providers en masse into harmful medical practice.

80. Similar to medicalization of transgender care, this government-backed proclamation regarding pain treatment came without sufficient preceding scholarly dialogue or even evidence that the suggested approach would actually solve the problem it claimed to be addressing (Mularski 2006). Nor did those "expert" physicians promoting increased use of opioids show any consideration for the potential long-term harms. Many patients suffer from physical and emotional pain, but when patient-driven medicine is allowed, too much compassion can cause harm.

THE POLITICIZATION OF GENDER CARE AND SUPPRESSION OF DISSENTING OR QUESTIONING VOICES

81. With rapidly growing cohorts of patients expressing novel symptom clusters in a new area of medicine where a limited evidence base exists, differences of opinion regarding clinical care for gender dysphoria are expected. It would be remarkable if there was uniformity of opinion. Furthermore, gender care is politicized, and opinions tend to cluster in a manner consistent with an influence of political ideology (Regnerus 2022).

82. Within this context of low-quality evidence and divergent opinions, there are bound to be calls for reasonable clinical safeguards. There are also serious reservations regarding the effectiveness and concerns about the risks from affirmative treatment for Gender Dysphoria (Clayton 2022A, Biggs 2022B).

83. Much of the push for "affirmative treatment" for gender dysphoria treatment has come from professional organizations such as the World Professional Association for Transgender

Health, Endocrine Society, American Academy of Pediatrics, American Psychiatric Association, and American Academy of Child and Adolescent Psychiatry.

84. Like other groups, professional medical organizations are susceptible to tribal influences and politicization. Medical professional organizations are large bureaucracies that serve many functions. They are important components of our medical system, but their influence and credibility can be misused. I have directly observed over the last decade, but particularly the last 5 years, that these organizations have prioritized a politicized, narrow vision of social justice advocacy. While this has arisen from good intentions, it has contributed to the creation and spread of misinformation regarding treatment of gender dysphoria.

85. I have directly observed that within these organizations, the members most enthusiastic about a certain type of medicine self-select into "special interest groups" or committees. For instance, the psychopharmacology committee is filled with supporters of using psychopharmacology, and the psychotherapy committee is populated by members enthusiastic about psychotherapy. Committees on gender and sexuality have been no exception. By participating in a committee, a small group of people can establish themselves as content experts within their organization.

86. Using committees as content experts usually works well, as it did during my eight years as co-chair within AACAP's media committee. AACAP leadership utilized our input to make decisions about clinical recommendations, public education, or relevant legislation.

87. As gender clinics spread across America in recent years, enthusiasts of "gender affirming care" self-selected into these clinics and also into gender-relevant committees. In my experience, most physicians are wary of the very concept that it can be beneficial to block puberty

or give cross-sex hormones to developing minors. Thus, those who venture into medicalized gender care are already a select few who bring to this work certain viewpoints and aspirations. Just as with the psychopharmacology or psychotherapy committee members, gender committee members have strong personal and professional investments in the success of their favored type of treatment. This creates a well-intentioned but homogenous group of supporters of "gender affirming care."

88. Even the annual meeting scientific program co-chair at the American Academy of Child and Adolescent concurs that one-sided committees distort scholarly dialogue: "I actually share some of your concerns about AACAP, or at least the AACAP Program coming down too heavily on one side of politically charged topics where consensus is not as clear cut as some would represent. To some degree the program is based on input from various AACAP committees and if the committee on gender issues or other issues is too one sided, the program committee is in a tough spot. Our committees are considered our experts." (Personal communication via email May 23, 2023 from James McGough). Without the knowledge of most members of a professional organization, as few as the dozen members in a committee can steer these organizations' leadership to advocate for treatments or policy positions. Once medical organizations have come out with policy statements, clinical practice guidelines, and press releases advocating strongly for a position, they have difficulty accepting they may have misstated evidence, advocated for unwise policy, or otherwise caused harm.

A. American Academy of Pediatrics

89. The highly influential 2018 Policy Statement from the American Academy of Pediatrics (AAP) (Rafferty 2018) contains a preamble confirming that the author[2] wanted his Policy

[2] Dr. Rafferty alone "conceptualized the statement, drafted the initial manuscript, reviewed and revised the manuscript, [and] approved the final manuscript as submitted." (Rafferty 2018).

Statement to be an advocacy document; the document begins with "As a traditionally underserved population that faces numerous health disparities" and ends with "while eliminating discrimination and stigma." These themes are continued in the introduction and throughout the document. This Policy Statement contained many citation errors, overstatements, and mischaracterizations of the evidence base (Cantor 2020). The policy statement unfortunately denigrated and mischaracterized the longstanding and well-regarded clinical approach of watchful waiting, which the statement called "outdated" and claimed that "watchful waiting is based on binary notions of gender in which gender diversity and fluidity is pathologized." In fact, watchful waiting respects fluidity and identity development to a greater degree than "gender affirming care" because it leaves room for the patient to continue to grow in his or her identity. This policy statement has been particularly detrimental to the scholarly exchange of ideas related to gender dysphoria treatments, as it used the prestige of the AAP to privilege the concept of "affirmative care" and denigrate other treatment. It also increased momentum to enshrine social transition and access to medical treatments in minors, whether or not these are prudent or evidence-based approaches.

90. Rather than encourage scholarly debate, the American Academy of Pediatrics has gone to great lengths to suppress its own members' concerns about gender-affirming treatments (Mason 2022). When an AAP fellow explained in the *Wall Street Journal* how the AAP had quashed member resolutions to conduct a systematic evidence review and reconsider its positional stance on "gender affirming care" (Mason 2022), the AAP's President responded publicly with multiple mischaracterizations of the debate, distortions of the AAP's own advice to clinicians, and divisive rhetoric characterizing those who urge caution as "anti-trans." (Szilagyi 2022).

91. Organizations' political activisms have important ramifications and create a false impression that gender-affirming treatment rests on strong and settled science. Two recent press

releases provide examples. The September 28, 2022 American Academy of Pediatrics (AAP) press release regarding the State of Oklahoma condemns any limits on gender-affirming health care. Defending scope of practice is typical for medical associations. Yet the press release frames these limits as discrimination based on gender identity, a moralized characterization of restrictions on care.

92. American Academy of Pediatrics' opposition to Oklahoma's limits on moral grounds (discrimination) fails to acknowledge ethical concerns regarding treatment of children with gender dysphoria. Those concerns of "gender affirming care" include large-scale, potentially irreversible damage to minors and a dysfunctional informed consent process that overstates the evidence of benefits and does not offer alternative treatments—all in a context in which many providers of gender affirming treatments do not even acknowledge that the recent surge in patients expressing gender dysphoria represents a never before-studied cohort without long term outcomes (Levine 2022). This is an example of competing moral frameworks, each express valid concerns. As such, a more appropriate perspective from a medical organization would be a call for reasoned dialogue to evaluate the moral claims on each side and examine the logic and data behind these moral frameworks and treatments. It is ethical to seek to find more cautious ways to care for and support youth with gender dysphoria or to seek a higher level of evidence before allowing minors to make permanent decisions regarding altering their bodies.

93. Curiously, the AAP statement invokes parental rights, but without clarifying if the AAP supports the very likely majority, who do not want hormonal or surgical treatment for their child's gender dysphoria. This AAP statement misses an opportunity to show respect for those who disagree, and would rather frame these parents as biased against their own children, which is an indication of how politicized the AAP organization has become.

94. The AAP has also demonstrated its politicization by publishing statements and joining amicus briefs across a range of political issues, including immigration (American Academy of Pediatrics 2017), affirmative action (Brief for Amici Curiae Association of American Medical Colleges et al. 2022), firearms (Letter to Chairman Patrick Leahy 2022), critical race theory (Trent et al. 2019, AAP Board of Directors 2020, AAP 2022), and climate change (Council on Environmental Health et al. 2015).

95. As the Liaison from the American Academy of Child and Adolescent Psychiatry to the American Academy of Pediatrics, I sat on the AAP's Council on Communication and Media and witnessed the organization's increased politicization firsthand.

B. American Academy of Child and Adolescent Psychiatry

96. Like other medical organizations, the American Academy of Child and Adolescent Psychiatry (AACAP) has come out strongly for affirmative care, supporting the opinion that minors have the emotional and cognitive development to consent to treatments that may have adverse lifelong consequences such as sterility. Yet when the question was mandatory life in prison in *Miller v. Alabama*, the AACAP (and the American Medical Association) Amicus Curiae (2012 p. 2-3) claimed:

> Scientists have found that adolescents as a group, even at later stages of adolescence, are more likely than adults to engage in risky, impulsive, and sensation-seeking behavior. This is, in part, because they overvalue short-term benefits and rewards, and are less capable of controlling their impulses, making them susceptible to acting in a reflexive rather than a planned voluntary manner. Adolescents are also more emotionally volatile and susceptible to stress and peer influences. In short, the average adolescent cannot be expected to act with the same control or foresight as a mature adult.

97. Unless this organization is willing to backpedal on its well-substantiated and well-documented arguments in *Miller v. Alabama*, how can it basically argue the opposite when it

comes to consent for irreversible treatment within the context of low-quality evidence and significant risk of harm?

98. In 2018, Lisa Littman presented her research data at an American Academy of Child and Adolescent Psychiatry conference and received personal enmity which caused a colleague to remark he had never seen a presenter at a conference treated with such hostility. I did not attend live but later watched the presentation online and also heard the many demeaning and unprofessional comments directed toward Dr. Littman.

99. Members of AACAP (and other organizations) who observe scholars being condemned in this manner will certainly think twice before voicing their concerns about gender affirming care. This polarization and moralization can create a "spiral of silence": an appearance of agreement because a small but vocal moralizing group dominates the discussion (Noelle-Neumann 1974). This is consistent with my experience. I have been told by a range of child psychiatrists, from very senior AACAP "life members" to residents in training, that they are unwilling to openly express their viewpoint, but they do not see data or logic supporting "gender-affirming" treatments.

100. The 2022 AACAP conference featured at least six presentations related to gender dysphoria or transgender patients, none presenting new research. Yet a research symposium was rejected which was to include prominent international gender dysphoria researcher and clinician, Riittakerttu Kaltiala, MD, PhD, Dr. Littman, and detransitioners. The AACAP program committee co-chair James McGough later indicated via a May 28, 2022 email that this highly unusual rejection was in part due to "concerns" about the methods employed in several of the presentations and that detransitioners would be involved. It defies logic that the only time methods are a "concern" is when the results of the research raises questions about affirmative care. Furthermore, I am aware

of a number of presentations that have been accepted with the condition of making a small adjustment. The detransitioners as discussants could have easily been replaced as their only role would be to ask questions after the research was presented.

101. Dr. McGough indicates he took these concerns seriously. He referred concerned parties to "Aron Janssen, co-chair [of] the AACAP committee charged with taking the lead on trans issues." Dr. McGough also noted that "Aron is also on the program committee." As a program committee member "taking the lead on trans issues," Dr. Janssen would have significant power to support or suppress presentations. Those concerned with free exchange of scholarly ideas should notice the words Dr. Janssen chose in his 2021 "Perspectives" article (Janssen 2021), where he characterized legislative and political endeavors to limit medical care as "malicious changes" that "provide fodder to perpetuate discrimination, fear, and exclusion." He specifically states: "It is our ethical responsibility to respond to this assault".

102. Dr. Janssen characterizes those arguing for caution regarding gender affirmative treatments as making "an effort to oppress." Like other enthusiasts, Dr. Janssen displays his willingness to demonize those urging caution and exaggerates the evidence base.

103. For those not familiar with the proceedings of medical conferences, research symposiums are eagerly sought out by the medical societies. The program chair, Dr. McGough, has commented to me personally that research symposiums are by far the easiest type of presentation to be accepted. For this same conference, I also submitted, with Drs. Kaltiala and Littman, a proposal for a Special Interest Group presentation, which was to feature data on detransitioning. This proposal would have created a space for discussion of data that raised questions about affirmative care. The proposal was also silenced.

104. For the October 2023 Conference, I offered Dr. Janssen the opportunity to be the discussant for a Clinical Perspectives session entitled *International Perspectives on Care for Gender-Dysphoric Children & Adolescents*. This presentation was to include researchers and clinicians from England, Sweden, and Finland, as healthcare authorities in each of these nations have dramatically curbed the availability of gender affirming care for minors as a result of the systematic reviews of the evidence they collected. Dr. Janssen not only refused to participate, but he also rejected the request to suggest another committee member to serve as discussant. As a replacement, we submitted the proposed session with the past President of the American Academy of Pediatrics serving as a discussant. Again, this presentation was denied.

105. Similarly, I also submitted for the AACAP 2023 conference a research symposium with researchers from England, Sweden, and Finland: *Epidemiology, Suicidality and co-morbidities of Gender Dysphoria, New International Findings*. This presentation was similarly rejected.

106. Even more revealing, the AACAP March 18, 2022 press release reveals the leadership's strident position by remarking on an education bill, outside psychiatrists' area of expertise. (AACAP 2022). AACAP's statement used politicized, derogatory phrasing by calling Florida's legislation the "Don't Say Gay or Trans" bill. The press release quotes the current president of AACAP, who demonizes supporters of the bill as unconscionable and implies that the supporters "target and harm LGBTQ+ youth." The American Academy of Child and Adolescent Psychiatry's leadership moralizes the debate, uses polarizing language, and does not engage in forthright discussion that must include skepticism, not just affirmation. Indeed, the AACAP has taken policy positions on a wide range of political issues, including climate change (AACAP Mar. 2022), gun control (AACAP June 2022), immigration (AACAP Oct. 2021, AACAP May 2018, AACAP Sept.

2017), affirmative action (Brief for Amici Curiae Association of American Medical Colleges et al. 2022), and critical race theory (AACAP, proposal deadline June 1, 2023; AACAP Jan. 2023).

C. American Psychological Association

107. The American Psychological Association has also taken seemingly contradictory positions on brain development in the context of two political issues: transgender care and the death penalty. The 2022 American Psychological Association Resolution on the Imposition of Death as a Penalty for Persons Aged 18 Through 20, Also Known As the Late Adolescent Class goes into significant detail regarding their position on brain immaturity through at least age 21:

> WHEREAS developmental neuroscience, including research on both the structure and function of brain development, establishes that significant maturation of the brain continues through at least age 20, especially in the key brain systems implicated in a person's capacity to evaluate behavioral options, make rational decisions about behavior, meaningfully consider the consequences of acting and not acting in a particular way, and to act deliberately in stressful or highly charged emotional environments, as well as continued development of personality traits (e.g., emotional stability and conscientiousness) and what is popularly known as 'character'.

I removed the many citations for clarity, but they can be found in the original document. The APA Resolution continues:

> WHEREAS it is clear the brains of 18- to 20-year-olds are continuing to develop in key brain systems related to higher-order executive functions and self-control, such as planning ahead, weighing consequences of behavior, and emotional regulation. Their brain development cannot be distinguished reliably from that of 17-year-olds with regard to these key brain systems.

108. It is clear the American Psychological Association understands that the entire cohort of minors submitting to irreversible hormones and surgeries has under-developed abilities to understand the risks and meaningfully consider the consequences. I agree with the American Psychological Association that these deficits maintain up until at least age 21, and the courts should take these impairments seriously in *all* contexts.

D. American Psychiatric Association

109. Political and social pressures are not new to this line of research and clinical care and do not come from only one political pole or fraction of society. Yet especially within the last decade, academia, including academic medicine, has become more tribal, more moralizing, and more likely to attempt to silence divergent opinions (Bindewald 2021).

110. I witnessed these dynamics personally at the American Psychiatric Association 2022 annual conference. At the Clinical Perspective *The Management of Adolescent Onset Transgender Identity: Should "Best Practices" Change* on May 24, 2022, there was a preamble. In a practice I had never before seen at a conference, representatives from the American Psychiatric Association who were monitoring the event were asked by leadership to read a statement prior to the presentation indicating that the content of the presentation clashed with official proclamations of the organization. During this Clinical Perspectives, four speakers presented convincing data and opined that they questioned the evidence base and logic supporting current affirmative psychotherapy and medicalized practice regarding the treatment of transgender youth.

111. Most of the audience respectfully sat while enjoying the thoughtful presentation. Yet a small crowd in the audience was disruptive. There were interruptions of the presentation by a member of the crowd who repeatedly provided his input. During the question-and-answer session, a series of "questions" were rather hostile ad-hominem statements towards the presenters. Only a tiny fraction of the questions responded to any of the evidence or viewpoints presented. I have never previously observed any comparable unprofessional behavior or hostility toward presenters in any medical or psychiatric conference.

112. The politicization of the American Psychiatric Association can also be seen in the many political positions taken by the organization, including climate change (Ursano et al., n.d.),

firearms (Letter to Chairman Patrick Leahy 2022, American Psychiatric Association Aug. 2019), affirmative action (Brief for Amici Curiae Association of American Medical Colleges et al. 2022), and immigration (American Psychiatric Association Stress & Trauma Toolkit).

E. WPATH

113. The World Professional Association for Transgender Health (WPATH) is an international, multidisciplinary, professional association whose reported "mission is to promote evidence-based care, education, research, public policy, and respect in transgender health."[3] WPATH Standards of Care (SOC) documents share some features with what a medical organization would call clinical practice guidelines. The 2011 edition of WPATH's SOC documents are known as SOC-7, and the 2022 version is SOC-8. The authors of SOC-8 state: "The overall goal of SOC-8 is to provide health care professionals (HCPs) with clinical guidance to assist [transgender and gender-diverse] people in accessing safe and effective pathways to achieving lasting personal comfort with their gendered selves with the aim of optimizing their overall physical health, psychological well-being, and self-fulfillment."

114. Well-being and self-fulfillment are ephemeral goals to apply to medical practice. WPATH frames essential aspects of its guidelines in vague, non-medical terms: WPATH claims that mental health symptoms are to be "addressed" before puberty blockers or hormones. (Coleman S62). "The adolescent's mental health concerns (if any) that may interfere with diagnostic clarity, capacity to consent, and/or gender-affirming medical treatments have been addressed." Yet the vague wording "addressed" is without any clear boundaries and enables enthusiastic practitioners to initiate treatment under almost any conditions.

[3] World Professional Association for Transgender Health, *Mission and Vision*, https://www.wpath.org/about/mission-and-vision (last accessed May 10, 2023).

115. Dahlen et al. reviewed WPATH SOC-7 as part of a systematic review and quality assessment of international clinical practice guidelines for gender minority/trans people. They noted that WPATH SOC-7 "contains no list of key recommendations nor auditable quality standards." (Dahlen et al., 2021). Among the principal findings was that WPATH SOC 7 "cannot be considered 'gold standard."' The WPATH review scored poorly on editorial independence, applicability, and rigor of development. The review scored better on scope, stakeholder involvement, and clarity of presentation. The reviewers noted that WPATH and other international clinical practice guidelines tended to prioritize stakeholder involvement rather than methodological rigor.

116. Among the implications were that "[c]linicians should be made aware that gender minority/trans health [clinical practice guidelines] outside of HIV-related topics are linked to a weak evidence base" and that "[o]rganizations producing guidelines and aspiring to higher-level quality could use more robust methods, handling of competing interests and quality assessment."

117. Despite the well-known methodological weakness of SOC-7, WPATH created SOC-8 in a similar manner, only selectively using the conventions expected to create a trustworthy clinical practice guideline. In his report, Dr. Karasic claims: "These recommendations are evidence-based, informed by a systematic review of evidence and an assessment of the benefits and harms of alternative care options, as well as expert consensus." (P9-10).

118. Yet contrary to Dr. Karasic's claim, WPATH only selectively applies rigor to SOC-8. WPATH SOC-8 did not clearly document what reviews were attempted, raising the possibility that reviews were stopped or buried upon unfavorable results. WPATH SOC-8 obscures the most important element required for a trustworthy clinical practice guideline: the assessment of the strength of the evidence used to make recommendations. Hiding the strength of evidence obscures

critical data from readers trying to evaluate the evidence base for an organization's recommendations. (Murad 2017).

119. My analysis is supported by the British Medical Journal Investigations Unit's review of the evidence for transgender treatments, including the WPATH SOC-8. (Block 2023). The British Medical Journal (BMJ) investigators interviewed Gordan Guyatt, M.D., an internationally recognized leader on systematic reviews and, in fact, the co-developer and first author of the original GRADE guidelines. BMJ also interviewed expert Mark Helfand, professor of medical informatics and clinical epidemiology at Oregon Health and Science University. Helfand noted that "WPATH's recommendations lack a grading system to indicate the quality of the evidence—one of several deficiencies."

120. This same BMJ article highlighted transparency issues with the guidelines: "Both Guyatt and Helfand noted that a trustworthy guideline would be transparent about all commissioned systematic reviews: how many were done and what the results were." But whereas SOC-8 claimed that the evidence was so limited regarding transitioning treatments for gender dysphoric youth that "a systematic review regarding outcomes of treatment in adolescents is not possible," as Guyatt pointed out, "systematic reviews are always possible, even if few or no studies meet the eligibility criteria." (BMJ 2023).

121. While SOC-8 is beyond the scope of this report to review completely, I must note four major concerns as a mental health professional:

a. SOC-8 makes no analysis for why it prioritizes affirmation of gender identity over affirmation and acceptance of the physical sexed body. For clinicians and psychotherapists, these trade-offs are complex matters in developing adolescents and fundamental to treatment. SOC-8 treats the question

as though it had a clear answer supported by the evidence: affirmation always. That is an answer based on ideology rather than clinical wisdom or science.

b. SOC-8 suggests consumer-driven medical and surgical interventions and deems these medically necessary without adequate supporting evidence. In no other field of medicine does a life-altering intervention become medically necessary based on the desire of the patient.

c. SOC-8 normalizes self-mutilation via inclusion of "Eunuchs" as just another non-binary category without any suggestion that these individuals require mental health assessment prior to any consideration of chemical or surgical procedures.

d. SOC-8 downplays concerns related to de-transitioning.

122. There have been several other episodes I have learned about that have caused me to conclude that I do not feel comfortable relying on WPATH or its U.S. affiliate, USPATH, to guide my care of gender dysphoric patients.

123. For instance, it appears there are calls for ideological hegemony at USPATH. Zander Keig, a longstanding WPATH member and former chair of the USPATH advocacy committee, related on a public podcast that he received a call from Dr. Joshua Safer, a WPATH board member, former president of USPATH, and co-author of the 2017 Endocrine Society Clinical Practice Guidelines. (Heterodorx 2023). According to Keig, he had agreed to be an advisor to the Gender Dysphoria Alliance, an organization composed of transgender people, detransitioners, and researchers that is "committed to thoughtful and respectful dialogue" and hearing from multiple perspectives regarding gender dysphoria. Presumably because the Gender Dysphoria Alliance is

not unquestioningly "affirming" and includes voices of transgender individuals who are skeptical of WPATH's guidelines, Dr. Safer asked Keig to resign from USPATH or threatened to remove him as chair of the USPATH advocacy committee due to advising the Gender Dysphoria Alliance. Keig also stated that Dr. Safer suggested that he (Keig) lie about the reasons for resigning. This instance is illuminating on multiple grounds. First, silencing a member of USPATH and cleansing USPATH leadership of dissenters brings into question the ethics and scientific integrity of Dr. Safer. This is made more concerning because Dr. Safer was an author of the Endocrine Society Clinical Practice Guideline and other scientific research articles promoting transgender care. Second, as in this episode Dr. Safer appears to be representing the USPATH board, this demonstrates an institutional problem. WPATH and USPATH claim to be open to scientific exchange and diversity of thought, but their leaders risk termination if they are affiliated with a less politicized and ideological transgender group, such as the Gender Dysphoria Alliance.

124. Similarly, USPATH has clearly become an uncomfortable place for clinicians or researchers whose perspectives do not fall into a narrow ideological slice represented by USPATH (Ciszek 2021). In 2016, for instance, renowned psychologist Kenneth Zucker had his USPATH conference presentation drowned out by protestors because he had previously suggested that affirmation-only therapy could cause gender dysphoric children to "persist" when they would otherwise have their gender dysphoria "desist." After shutting down Dr. Zucker's panel, the activists made demands to the USPATH board, which subsequently removed Dr. Zucker from remaining panels and apologized to the activists for allowing Zucker to attend the conference. The board thus rewarded the activists who silenced scholarly debate.

125. Even prominent leaders at USPATH / WPATH like Laura Edwards-Leeper and Erica Anderson have acknowledged that, as they titled their Nov. 24, 2021 Washington Post article, "*The Mental Health Establishment is Failing Trans Kids*." (Anderson 2021). USPATH and WPATH responded to the article by releasing an Oct. 12, 2022 joint statement condemning "the use of the lay press … as a forum for the scientific debate." (WPATH/USPATH 2022). The board of USPATH then privately censured Anderson, who later resigned as president. (Bazelon 2022).

126. Based on these and other public accounts, I conclude that USPATH and WPATH are not scientific organizations that prioritize the search for truth and the safeguarding of vulnerable children, but instead are organizations that seem to prioritize preserving their image and enforcing their advocacy positions.

F. Endocrine Society

127. Similar to AACAP and AAP, it appears that the Endocrine Society also takes a polarized position and misstates the strength of the evidence regarding "gender affirming care." In particular, the April 20, 2022 press release, "Endocrine Society Opposes Florida Department of Health Policy on Gender Dysphoria Treatment for Children and Adolescents," reveals overstatements of the strength of evidence and creates the false appearance of consensus in the medical community. This statement mischaracterizes puberty delaying medication as a "safe, reversible and conservative approach." This statement claims that attempts to restrict care are based on politics, rather than acknowledging legitimate concerns. It is interesting that the organization cites the Endocrine Society's own clinical practice guidelines. Endocrine Society's guidelines themselves graded the supporting evidence as low or very low quality for their clinical recommendations.

128. Another area of concern is the relationship between WPATH and Endocrine Society. It appears that nine out of ten authors of the Endocrine Society Clinical Practice Guideline are

also WPATH leaders or authors. (Hembree 2017). This shows that a small number of physicians, empowered by these organizations, can create the false impression of broad consensus through campaigns of advocacy, especially when they believe they are fighting for a virtuous cause.

129. Dr. Shumer's writings likely reflect the views of the enthusiasts in WPATH and the Endocrine Society. In his 2015 paper with Norman Spack, he states in the abstract that the 2014 Pediatrics article by De Vries "should help to silence critics." This word choice, to "silence critics," illustrates his disdain for those urging caution and perhaps also comfort with suppressing scholarly dialogue. In his conclusion Dr. Shumer states: "LGBT (Lesbian, Gay, Bisexual, Transsexual) rights have become the civil rights issue of our day. Transgender people, often the forgotten caboose on the LGBT train, are emerging and demanding competent and compassionate medical care." (Shumer 2015). By his own admission, Dr. Shumer celebrates his work within a heroic framework of fighting forces of bias and discrimination, which increases risk for confirmation bias, selectively looking for evidence to substantiate already-held conclusions. This virtuous sense of self must at least raise concerns as to whether Dr. Shumer and other advocates engage in sober reviews of the evidence.

130. These professional organizations' portrayal of medical interventions for gender dysphoria as both effective and virtuous has had a chilling effect on scholarly dialogue regarding gender dysphoria in the medical community.

G. Medical Literature

128. Medical and psychiatric journal editors are surely aware of their affiliated professional organizations' policy statements and political advocacy. Since the Endocrine Society, American Academy of Pediatrics, American Psychiatric Association, and American Academy of Child and Adolescent Psychiatry have all been openly involved in political advocacy in support of

gender-affirming care, their journals are no longer scientifically neutral. This politicization is reflected in the editors' actions as medical and psychiatric journals have recently attempted to consolidate favorable opinion toward gender-affirming treatments for gender dysphoria rather than promote open scholarly debate.

129. Not surprisingly, skeptical voices have been difficult to find within any of the journals of the Endocrine Society, American Academy of Pediatrics, American Psychiatric Association, or American Academy of Child and Adolescent Psychiatry. Journal editors have wide discretion to filter topics that are covered in their journals by choosing what articles are sent for review, commentaries, clinical perspective, vetting Letters to the Editor, guiding what is included in the book review column, and setting policies. It is curious that there has been minimal dialogue exploring the unanswered questions related to informed consent in medical journals associated with medical organizations. Instead, these matters are left to be discussed in academic journals not affiliated with these organizations. (Latham 2022, Levine 2022).

130. The medical journal I follow most closely, *The Journal of the American Academy of Child and Adolescent Psychiatry*, has only published articles seeking conformity of thought with gender ideology and affirmative care and has not allowed actual scholarly dialogue to be voiced. This can be seen across commentaries (Dixon 2022), clinical perspectives (Turban 2017, Turban 2018), and book reviews (Suto 2021, Chilton 2021, Kim 2021).

131. The 2017 Turban article, for instance, provided the perspectives of transgender and gender nonconforming youth; reading that viewpoint can certainly be valuable for clinicians. Yet most striking were the youths' ideological assertions, misunderstanding of the evidence, and pleas for their physicians to believe suppositions such as that "[s]exuality and gender are two different things. TOTALLY separate" and "[p]uberty blockers and cross-sex hormones can save my life."

It also contained a pressure to join the movement: "Let me know that you are on my team." These youth somehow have gotten the impression there is no doubt regarding the safety and efficacy of hormones and surgery. They also have the belief that changing society is the solution to their mental health challenges: "If I am depressed or anxious, it's likely not because I have issues with my gender identity, but because everyone else does." More striking was that the authors expressed agreement with the youths' ideology. The authors conclude: "Likely due to a combination of minority stress and dysphoria related to being 'trapped in the wrong body,' these young people are disproportionately burdened by depression, anxiety, and suicide attempts." The authors contend depression, anxiety, and suicide attempts "likely" arise from minority stress and as a result of gender dysphoria (Turban 2017). Yet as detailed throughout this report and cited, it appears more likely that those with pre-existing psychological disturbance are more likely to later express gender dysphoria. (Bechard 2017, Diaz 2023, Littman 2018, Kaltiala 2015, Moradini 2022).

132. *The Journal of the American Academy of Child and Adolescent Psychiatry* even published a Commentary that pressured researchers to adopt progressive gender theories to "become allies" (Dixon 2022). It is curious but revealing that the participants seemed uninterested in core unanswered scientific questions, such as why individuals experience themselves as nonbinary or transgender. Conversely, the youth and authors used the commentary to push researchers to adopt ideology and allyship. These pressures on scholars are antithetical to the scientific method and have been a corrupting force in much recent research and academic dialogue regarding sex and gender. This politicized, low-quality scholarship has minimal credibility and is a prime example of how medical journals have prioritized advocacy and ideology over trustworthy science.

133. For example, with two child and adolescent psychiatric colleagues, in response to Dixon et al., we wrote a Letter to the Editor of the *Journal of the American Academy of Child and*

Adolescent Psychiatry discussing the problems with the article cited above; the journal editor refused to even send this letter out for review. Not only are the articles one-sided, but the peer review process regarding gender medicine within medical journals has become dysfunctional. Many recent examples show how prominent medical journals ignore significant weakness in methods, allow erroneous conclusions, and overstate the strength of the evidence when articles support affirmative care or related concepts (Biggs 2020C, Deangelo 2021, Kalin 2020, Giovanelli R. 2022). A few years ago, for instance, the *Journal of the American Psychiatric Association* published a study with an erroneous positive conclusion regarding gender surgeries in Sweden. The article prompted a flurry of letters to the editor that pointed out serious problems with the methodology and resulted in significant revision, including to the study's central finding (Bränström 2020). As discussed above, in 2018, Lisa Littman published an article that revealed aspects of the rapid spread of gender dysphoria in adolescents. After this research was peer reviewed and published, the journal PLOS ONE had a re-editing of the publication with a commentary added. (Littman 2019). This showed a disregard for the typical rules of scientific discourse because, importantly, this was not a correction; there was no finding of error, misconduct, or faulty methods with Littman's original paper. As confirmed by the PLOS ONE re-review, Dr. Littman's research methods were unremarkable and comparable to other mental health research.

134. Precisely because of the data supporting Littman's theories of Rapid Onset Gender Dysphoria, many advocates of medicalized treatment of youth with gender dysphoria appear to have panicked in an attempt to suppress scientific exploration rather than reformulate their own deeply held beliefs. Brown University also did not make any effort to defend Dr. Littman from attacks on her freedom to pursue science.

135. This antagonism of Dr. Littman was not about her methods, but rather that her data indicated that gender dysphoria was spreading in a pattern consistent with social influence. The affidavit of whistleblower Jamie Reed (Reed 2022) shows how this worked on a direct level in a gender clinic: "Doctors at the Center would ignore and dismiss as social contagion the claims about the tics and multiple personalities; but then those doctors would uncritically accept the children's statements about gender identity and place these children on puberty blockers and cross-sex hormones."

136. Similarly, clinicians at the Tavistock center, which before its closure was the world's biggest gender identity service, documented their own experience with similarly-named "adolescent onset" gender dysphoria. This involves gender dysphoric patients presenting without any noticeable symptom history prior to or during the early stages of puberty. (Hutchinson 2020). They further note how clinicians around the world are witnessing the phenomenon they call "adolescent onset gender dysphoria" and how unhelpful it is to suppress research or malign scholars who bring uncomfortable facts to light: "Unless we are free to discuss, explore, and research differential presentations of gender dysphoria, the range of interventions which might best serve each young person may not be available to them. We do not think that this is good enough for our patients."

137. Dr. Littman's other heresy was revealing how many parents perceive the gender-affirming approach to be dysfunctional. (Littman 2018). Now a similar controversy is brewing with another paper that provides data behind the ROGD concept, "Rapid Onset Gender Dysphoria: Parent Reports on 1655 Possible Cases" (Diaz 2023). This research documents parent reports from a convenience, non-neutral sample. Yet it explicitly discusses the disadvantages of such an ap-

proach and the rationale for publishing the data. Like Littman's work, this data undermines theories that gender identity is primarily biologically based, a theory advocated by Drs. Shumer, Karasic and Turban in their reports.

138. Research that runs counter to the prevailing orthodoxy causes panic among gender ideologues and activist scholars. Again, a mob has arrived to attempt to undermine credible research. This is an excerpt from the International Academy of Sex Research (IASR) listserv in response to the publication of the Diaz / Bailey article:

> Dear IASR members,
> In the interest of transparency, we want to communicate to the Membership about recent concerns regarding a publication in our official journal, the Archives of Sexual Behavior. On March 29th, the journal published an article authored by Suzanna Diaz & J. Michael Bailey entitled, "Rapid Onset Gender Dysphoria: Parent Reports on 1655 Possible Cases." Since its publication, significant concerns about the ethical conduct and integrity of the editorial process have been raised about this study. . . . [signed by] The IASR Executive Committee.

(Bailey 2023).

139. This focus on the "editorial process" only seems to go one way on this issue, against exploration of the massive rise in gender dysphoria and against scholars like Dr. Bailey and esteemed editors like Kenneth Zucker.

140. There are many more examples of politicization squelching scholarly research. This includes the firing and restricting of research data from Laura Favaro by City University of London as she attempts to research the perspective of academics with regard to gender issues. Ms. Favaro appears to have found a culture of fear and suppression regarding gender issue. As a result, this data is hidden and may never be revealed. (Sales 2023).

141. In February, UCLA researchers were forced by activists to pause or perhaps abandon their study because it aimed to expose transgender individuals to different views of themselves. The researchers "explained that 'by demonstrating that body-self incongruence was linked

to brain structure and function, we aimed to help provide a biological basis and increase empathy for the life stories of transgender individuals.'" (Grant 2021). Yet the activists who helped shut down the research revealed their disdain for this basic research because in their minds: "It is suggestive of a search for medical 'cure,' which can open the door for more gatekeeping and restrictive policies and practices in relation to access to gender-affirming care." (California LGBTQ HHS Network 2021).

142. Similar dynamics are in place even in newsletters. A colleague told me about a difficult experience with editors of the American Academy of Psychiatry and the Law Newsletter. The editors would not permit him to describe in his article the actual problematic behaviors of youth who declared themselves to be transgender in his inpatient unit. This silencing of actual clinical situations undermines the exchange of ideas on how to best provide clinical care.

143. Open inquiry is the ability to ask questions and share ideas without risk of censure. It is fundamental to medical research and scientific progress. Within medicine, the ability for constructive disagreement and the expression of divergent opinions has withered with regards to questions of biological sex, gender, and gender medicine.

144. Complex ethical issues regarding treatment of gender dysphoria deserve attention. Yet pressures to accept affirmation treatment as being the most virtuous and only effective approach discourages good faith scholarly dialogue. Furthermore, the characterization of those who oppose gender affirming care as transphobic or hateful has been used to justify silencing scholars whose data or logic does not support the gender-affirming approach. This occurred with Lisa Littman. Former sex researchers have left the field due to the harassment and intellectual bullying they received (Soh 2021).

145. My personal interactions with many thoughtful well-regarded psychiatrists display a full range of views. In my experience, most child and adolescent psychiatrists consider automatic affirmation inappropriate, even though many are willing to use affirmative approaches selectively. (Evans 2021). Most psychiatrists are willing to admit we don't have enough research to really know how to proceed.

146. Within medicine and academia, we need to create space to allow input from those many, I believe the majority, who hold the opinion that logic and the evidence base do not support using the "gender affirming care" model to treat gender dysphoria in youth. We require a frank discussion of the moral issues involved, including moral hazards associated with medical treatments for gender dysphoria. Currently, I see little evidence of this sort of scholarly dialogue happening.

HOW ADVOCACY UNDERMINES SCIENTIFIC DISCUSSION AT MEDICAL ORGANIZATIONS

147. The major medical organizations involved with promoting "gender affirming care" have relinquished their former role of curators of neutral science with regards to gender dysphoria. They have adopted unproven theories, become advocacy organizations, and have used their prestige to support their approved opinions and ideology. They have made public statements dismissing or even demonizing scholars who raise concerns. It cannot be seen as a coincidence that whereas there is serious debate throughout society and throughout the globe, little to none is to be found at the Endocrine Society, the American Psychiatric Association, the American Academy of Child and Adolescent Psychiatry, the American Academy of Pediatrics, or WPATH. Even more concerning, their respective journal editors, as shown, have also chosen advocacy over science.

148. These advocates convinced the organizational leadership to support affirming care in large part by framing medicalized treatments for gender dysphoria as "rights" and "discrimination" issues rather than an examination of evidence. This moralized and tribalized gender medicine and thereby stifled open exchange and silenced skepticism within medical journals. As these medical organizations put their prestige and influence behind this type of care, those overseeing conference programs, newsletters, and press statements and the editors of journals systematically distorted scholarly dialogue by promoting medical interventions. Moralizing and advocacy silenced concerned physicians, but most didn't even know their organizations had staked out such extreme stances. Thus, the members of these professional medical organizations have never had an opportunity to observe, or participate in, open and honest dialogue regarding the evidence for transgender care. As such, the positions of these organizations reflect mostly a tribal mentality and the politicization of gender affirming care. It does not reflect the views of members who have had a sober review of the evidence base and decided celebratory support of gender affirming care is warranted.

131. None of the medical journals of the organizations listed have meaningfully explored any of the theories underpinning adolescent transgender care. Levine (Levine 2023) recently listed the assumptions misrepresented as facts:

- The emergence of a trans identity is the result of reaching a higher level of self-awareness.
- Whether the trans-identity emerges in very young children, older children, teens, or mature adults is authentic and will be lifelong.
- All gender identity variations are biologically determined and inherently healthy.
- The frequently co-occurring psychiatric symptoms are a direct result of gender incongruence (the so-called "minority distress" model).
- The only way to relieve, or prevent, psychiatric problems is to alter the body at the earliest signs of puberty.
- Psychological evaluations and attempts to address psychiatric comorbidities should only be used to support transition.

- Attempts to resolve gender dysphoria with psychotherapy range from ineffective to harmful.
- Gender-dysphoric youth must have unquestioning social, hormonal, and surgical support for their current gender identities and desired physical appearance.
- All individual embodiment goals, even those that do not occur in nature, must be fulfilled to the full extent technically possible.
- Science has proven the benefits of early gender transition, and low rates of regret and detransition further validate the practice.

Exploring the assumptions listed by Levine should be the top priority of medical journals. If the journals were scientifically neutral, this dialogue would have occurred prior to making recommendations based on weakly supported theories.

149. I offer examples of the kinds of discussions that should be occurring with frequency in the medical organizations with regard to how best to treat young people suffering from gender dysphoria, but sadly are not.

Psychotherapy

150. Patients presenting with gender dysphoria have real symptoms, typically with other comorbid mental health disorders. These patients require validation and support. I recommend their mental health treatment start with psychosocial supports and psychotherapy (Schwartz 2021). In psychiatry, we typically refer to other providers such as social workers, psychologists, and licensed clinical therapists, who tend to provide the bulk of psychotherapy. Despite this, as noted in my background, I have extensive experience with psychotherapy and received additional training in a number of psychotherapies (talk therapies) including Cognitive Therapy, Rational Emotive Behavior Therapy, and Trauma-Focused Cognitive Behavioral Therapy. I also have training and experience in meditation and mind-body techniques including mindfulness meditation, trauma focused yoga, and Accelerated Resolution Therapy. It should also be noted I trained under and

worked for over a decade with former AACAP president Martin Drell, MD. Dr. Drell was intimately involved in training at LSU and ensured my training emphasized psychodynamic therapy and family therapy. Dr. Drell is a renowned psychotherapist among child and adolescent psychiatrists. I have experience utilizing psychotherapies, moreover I have taught psychotherapy to medical students and psychiatry residents for years. This background and experience distinguishes me from the majority of psychiatrists.

151. Quality psychotherapy includes the process of exploring patient life history, emotions, coping style, and thought patterns. This includes validating how patients feel, but it also includes teaching patients to not be guided solely by their feelings. Psychotherapy involves getting patients to recognize their own thought patterns, disturbed emotions, and, when appropriate, includes challenging irrational, self-defeating, and harmful beliefs.

152. There is not an evidence base to support strictly "affirmative" psychotherapy for gender dysphoria, where therapists actively agree with a patient's self-assessment. Automatically agreeing with patient viewpoints is a radical departure from traditional mental health treatments and psychotherapy. Psychiatrists do not "affirm" hopelessness in depression, delusions in schizophrenia, or distorted body image in anorexia or body dysmorphic disorder. The similarities between body dysmorphic disorder and gender dysphoria, and the contrast in how they are approached, provide significant evidence of how ideological and political forces have influenced medical practice (Kohls 2022).

153. Is it, for example, sensible, compassionate, or good medical practice to, for instance, soon after a sexual assault, automatically agree with a teen's new self-assigned gender label? What about when a nine-year-old girl who spontaneously says, "I feel like I am a boy"—do we immediately ask what boy name to call the child?

154. In psychotherapy with a patient with gender dysphoria, the therapist should neither advise a patient to change gender identity nor "agree" that a patient is the opposite sex. It is surely reasonable and compassionate for a psychotherapist to prefer a patient no longer to suffer with gender dysphoria. It would be inappropriate for a mental health professional to prefer gender dysphoria to continue. Yet, the false binary of affirmative psychotherapy versus conversion therapy for gender dysphoria is being used to push therapists away from consideration that acceptance of one's biological sex or resolution of gender dysphoria is a positive event.

155. This categorizing of quality psychotherapy as conversion therapy is a serious misunderstanding of the complexities of ethical and effective psychotherapy (Schwartz 2021, D'Angelo 2021). The term "conversion therapy" is often misused by the supporters of affirmative care as an attempt to devalue and pathologize approaches other than purely affirming a patient's gender self-identification (Griffin 2021, Evans 2020). The only conversion therapy which has ever been researched is the attempt to change, or convert, sexual orientation. Such conversion therapy is widely discredited, which is perhaps why lodging accusations of conversion therapy has been so effective at creating an all-or-nothing atmosphere concerning "gender affirming care."

156. For example, in Page 6 of his report Dr. Schumer details his ideology regarding gender identity, including claims that "attempts to force transgender people to align their gender identity with their birth sex (sometimes described as conversion therapy) have been found to be both harmful and ineffective."

157. However, Dr. Schumer only cites two studies, one authored by Dr. Turban, in which the limited methodology of an online, retrospective self-report in a non-representative sample can't support Dr. Shumer's claims. Firstly, regarding the effectiveness of therapies to help individuals

come to peace with their biological sex. If those therapies labeled conversion therapy were effective, those individuals exposed would not be present in the 2015 transgender survey. Thus, the cited study cannot say anything about effectiveness, because those successfully treated would no longer have transgender status, and thus would never have filled out the survey.

158. Secondly, retrospective self-report of a non-representative sample is such weak data that similar methodology (retrospective report from non-representative samples) is exceedingly rare in any peer-reviewed medical literature other than transgender medicine.

159. Dr. Schumer uses this weak evidence as substantiation for his claims, displaying he has not given substantial thought to the basic premises which underlie the gender affirming care he provides. This was on clear display during his deposition where he displayed his ignorance of the studies he cited regarding psychotherapy (p. 59 – 23 to p. 60 line 3). Regarding his theory that efforts to change gender identity are harmful and ineffective, when he lacks citations, Dr. Shumer turns to the supposed eminence of professional organizations: “These medical associations I know and respect, who have done more work than me trying to answer that question, have come to the conclusion that, no, it is not safe or effective.” (60 20-23).

160. Turban and Karasic make similar claims painting psychotherapy as harmful and ineffective, again without any substantial support. Dr. Turban and Karasic in their reports make attempts to frame psychotherapy as “conversion.” Dr. Karasic indicates medical authorities claim that “efforts to change gender identity are ineffective, can cause harm and are unethical.”(P 7). None of his citations provide data to back up this claim.

161. Dr. Karasic and Dr. Turban claim that it is unethical to help a person come to accept the reality of their biological sex. Approaches to get patients to accept and live comfortably with their bodies have a longstanding tradition in mental health treatments. Body positivity and body

acceptance are laudable goals and do not cause harm to healthy bodies as the gender affirming treatments using puberty blockers, hormones and surgeries do.

162. On page 17 of his report, Turban claims practices, termed "gender identity conversion efforts" have subsequently been linked to adverse mental health outcomes, including suicide attempts.

163. Dr. Turban cites his own flawed article to make claims about psychotherapy, which cannot be determined via the non-representative, retrospective online self-report he cites. Turban uses the softer wording that gender identity conversion efforts are "linked" with adverse outcomes and suicide. Firstly, there is no detail on what those surveyed experienced that they considered conversion therapy. Secondly, "linked" is all he can say because the actual connection is only retrospective self-report, which is notoriously unreliable.

164. Gender identity is often described as fluid, and as this implies, often changes over time, particularly in young people. When this was discussed in his deposition, Dr. Turban did not take the opportunity to clearly explain how gender is both fluid and biologically determined, nor what studies he believes resolve this paradox. (P21 line 17-25).

165. Gender identity fluidity is also why it is unwise to affirm a declared gender identity in a child.

166. Psychotherapists need space to ask questions about gender identity. Exploring gender identity is not conversion therapy.

167. Time-tested and widely effective psychotherapy approaches include supportive therapy or cognitive behavioral therapy. Cognitive behavioral therapy has proven effective for virtually every mental health condition it has been researched for, including the full range of anx-

iety disorders, depressive and mood disorders, disturbed anger, sleep disturbance and trauma reactions including Post Traumatic Stress Disorder. Due to the high levels of comorbidity of psychiatric disorders in patients with gender dysphoria, cognitive behavioral therapy could be extremely helpful as the same approach and techniques have proven effective with so many problems including anxiety and depression and in reducing self-harm.

168. Any psychotherapy should aim to help individuals gain a deeper understanding of themselves, develop coping skills, and provide a neutral, unbiased process. Beyond standard psychotherapies, more specific and nuanced approaches for gender dysphoria exist, such as Exploratory Therapy (https://genderexploratory.com/). This "talking therapy" allows time for exploration of mental health concerns without pushing an ideological or political agenda.

169. Advocates of affirmative treatment and their dismissal of other approaches can be especially harmful in the cases of gender dysphoria presenting in the context of severe pre-existing psychiatric illness.

170. TRAUMA

171. A child's gender expression can be a reaction to trauma rather than an intrinsic identity to be strictly "affirmed." This is what is termed diagnostic "overshadowing" in the Cass Interim Report of the United Kingdom's review of services for gender dysphoric youth: "Another significant issue raised with us is one of diagnostic overshadowing—many of the children and young people presenting have complex needs, but once they are identified as having gender-related distress, other important healthcare issues … can sometimes be overlooked." (Cass 2022, p. 17).

172. Psychotherapy could lead to the resolution of these comorbid illnesses. Psychotherapy is well known as a standard treatment for anxiety and depression. I can

provide three examples where distraction from standard treatment can harm patients, trauma, autism, and personality disorders.

173. Trauma: There is longstanding psychiatric literature showing that exposure to sexual trauma can lead to changes in gender expression (Cosentino 1993), and this has also been revealed by recent research on detransitioners (Littman 2021). A recent review on Dissociative Identity Disorder and co-occurring gender dysphoria showed frequent childhood sexual abuse (Soldati 2022). Thus, rather than allowing clinicians flexibility to proceed as longstanding clinical wisdom would dictate, advocates of affirmative treatment discourage discussion of the relationship between trauma and gender dysphoria. This affirmative model pressures clinicians to steer away from exploration whether a trauma reaction is the primary problem.

174. Relatedly, a core feature of Post-Traumatic Stress Disorder (PTSD) is avoidance, and in some patients, adoption of a transgender identity may be a method to avoid addressing the suffering caused by a trauma, such as a sexual assault. While this avoidance may temporarily block some negative feelings, in the long run, continued avoidance can lead to terrible consequences and a failure to resolve the trauma reaction. Repeatedly patients have described to me their physical and emotional distress when they are exposed to trauma reminders. Thus, they frequently have difficulty engaging in psychotherapy for PTSD. Even if they participate, they often actively avoid discussing their trauma.

175. The massive rise in expressions of gender dysphoria has been most pronounced in adolescent females. This is a population where assessment for and treatment of trauma should be a top priority. Furthermore, based on the link between sexual abuse and gender dysphoria seen in detransitioners, assessment and treatment of trauma symptoms should be prioritized. It is possible

that for many patients the delivery of trauma-based psychotherapy may cause the desistence of gender dysphoria, which in some cases could be considered a co-occurring disorder related to the trauma.

176. Struggles to get patients engaged in the best treatment is unfortunate as trauma focused therapies such as Trauma Focused Cognitive Behavioral Therapy have an excellent evidence base. Clinicians need to consider whether, especially for adolescent onset natal females, adopting a transgender identity is prompted in part due to avoidance. This is because expressing gender dysphoria within a medical system promoting gender affirming treatment forces the focus toward the gender identity and away from past trauma, trauma reactions, and fears of the future.

Autism

177. Autism Spectrum Disorders are neurodevelopment disorders. People with Autism Spectrum Disorder, by definition, have problems with social communication and interaction, along with restricted or repetitive behaviors or interests. People with Autism Spectrum Disorders are consistently shown to be at increased risk for developing gender dysphoria. (Cooper 2022). One review found gender dysphoria to be over four times as likely in patients with Autism Spectrum Disorders. (Hisle-Gorman et al. 2019). Another review found that compared to typically developing controls, autistic adults who endorsed the wish to be the opposite sex were found to have more mental health challenges, bullying, suicidal ideation, and worse quality of life. They also had worse autism symptoms and more co-morbid disorders than autistic adults who did not report the wish to be the opposite sex.

178. Autistic people experiencing gender dysphoria are a complex patient cohort. There is limited evidence of how best to help and support this specific population. Due to the neurocog-

nitive limitations in patients with Autism Spectrum Disorders, they may be more suggestible. Autistic patients struggle socially and often spend large amounts of time online. Due to their rigid and obsessive thought patterns, if they develop gender dysphoria, they can become fixated and preoccupied with receiving hormonal or surgical procedures, whether or not they understand the risks. Adolescent patients with Autism Spectrum Disorder can be incredibly insistent, single-minded, and determined. They also may have limited insight and minimal ability to anticipate the negative consequences of obtaining the object of their obsessions. Clinicians from Tavistock reported youth with Autism Spectrum Disorder need more time in assessment, which "may be illustrative of neurodivergent children needing more clinician-facing time to convey their experience" as they develop identity on different timelines and through different frameworks than neurotypical peers. (Churcher-Clark 2019). Until more is known about the specific outcomes related to this vulnerable population, caution with any clinical approach is warranted.

Borderline Personality Disorder

179. Personality Disorders are enduring patterns of inner experience and behavior that deviate from expected and cause distress and impairment in functioning. The epidemiology of personality disorders in individuals with gender dysphoria is unknown and estimates vary. (Furlong 2022). Many estimates of personality disorders in transgender populations have dramatically increased, such as 50% of adults, but others show smaller increases. One review of emergency room visits of transgender patients with diagnosed personality disorders was at 4%, versus a matched community sample at 1%. The hospitalized sample was at 5% among transgender patients versus 2% in controls. (Lam 2021). Little scholarly guidance exists regarding specific approaches related to the various personality disorders with comorbid gender dysphoria.

180. In Borderline Personality Disorder there is, by definition, an unstable sense of self, and this leads to frequent personality changes. This typically means sudden shifts in employment, relationships, sexual identity, frequent moves, and changes in types of friends. Patients with Borderline Personality Disorder often have early-life trauma and find many social environments invalidating. Patients with Borderline Personality Disorder have high levels of emotional dysregulation, self-harm, and substance use. This population is extremely difficult to treat.

181. With an unstable sense of self being a feature of the disorder, this patient population seems an especially poor candidate for affirming treatments, especially irreversible treatments. There are two psychotherapeutic approaches that have shown significant success. The most established is Dialectical Behavioral Therapy (Gillespie 2022), but Mentalization Base Therapy (Vogt 2019) also has significant evidence as a successful approach.

182. Especially for a young person developing signs of Borderline Personality Disorder, starting these proven approaches as early as possible is their best chance of avoiding a life course full of emptiness, struggle, and suffering. Again, in this patient population, a focus on gender-affirming treatments as the solution to this constellation of serious mental health problems is extremely problematic and appears likely to cause harm if it delays access to evidenced-based treatments.

183. Psychotherapy is an excellent treatment choice for youth with gender dysphoria. Yet in his report, Dr. Turban (p. 9) suggests, “Other than the gender affirming medical care banned under S.E.A. 480 there are no evidence-based treatments for adolescents with gender dysphoria.” Turban is precise and narrow in his language here because psychotherapy has been shown to be generally effective for many disorders. Psychotherapy just has not been systematically studied as

a solo treatment for gender dysphoria, mainly because up until recently the patient population has been so small.

184. Shumer, Turban and Karasic want the medical community to generalize the results of Dutch researchers on a narrowly defined small cohort of early onset gender dysphoria. Yet most youth presenting to gender clinics are adolescent onset females with significant co-morbidities, a very different patient population. Yet Shumer, Turban and Karasic refuse to generalize literally thousands of studies showing the positive results of psychotherapy to the current cohort of youth expressing gender dysphoria. For example, a recent **review of meta-analysis** of cognitive behavior therapy (CBT) yielded a final sample consisting of 269 meta-analyses (Hoffman 2012) that showed broad and deep efficacy of CBT. Please note the breadth and depth of this research: not 269 original studies, **269 meta-analyses** of CBT. This review examined CBT for: substance use disorder, schizophrenia and other psychotic disorders, depression and dysthymia, bipolar disorder, anxiety disorders, somatoform disorders, eating disorders, insomnia, personality disorders, anger and aggression, criminal behaviors, general stress, distress due to general medical conditions, chronic pain and fatigue, distress related to pregnancy complications and female hormonal conditions. The results are there to see, and while variation of effectiveness exists across conditions, CBT consistently proves its effectiveness (David 2018). Yet proponents of gender affirming treatments claim no therapy, CBT or otherwise would work for Gender Dysphoria. One has to wonder why they would stake out an extreme position so hostile to treatment so likely to be effective.

185. Furthermore, many of the gains which are claimed to come from medical treatments for gender dysphoria likely come from non-specific treatment factors, placebo effects, or concom-

itant psychotherapies. Because this patient cohort has so many co-morbidities, prioritizing hazardous medical treatment targeting gender identity over treating other disorders has no empirical basis and leads to other conditions being untreated or undertreated. This is what Dr. Cass described as "diagnostic overshadowing." (Cass 2022, p. 17). Supportive or other psychotherapies treating these other conditions entails minimal risk and does not require lifelong alteration of one's body.

Identity Development

186. Identity development is a primary task of teenagers. Erickson (Erickson 1968) noted this over 50 years ago, and identity involves many various self-concepts. Identity can include what neighborhood or school a teen associates with, what racial, ethnic, or religious group they arise from, what political or ideological groups one associates with and the many academic, extracurricular, work, or leisure activities that one engages in. Personal identity development evolves through interactions over time with many aspects of the world which provide meaning, provide socialization, and prompt self-assessment of one's place in society. Adults can look back at their life to realize how much their identity has changed since they were children or teenagers.

187. The development of sexual orientation for gay, lesbian, and bisexual youth can be one part of identity development that is particularly difficult during adolescences. The current mental health crisis, especially affecting teenage girls, is an indication that identity development struggles have increased overall.

188. Healthy identity development would not over-focus on one aspect of self. As hyper-social creatures, humans play different roles in our varied settings; educational, work, leisure, family, and communities. An over-intense focus on gender identity appears particularly harmful in the context of overall identity development.

189. Gender affirming care can negatively affect every stage of development as life becomes focused around gender identity. This seems especially problematic in youth struggling to form a multifaceted identity due to mental health problems like autism, trauma reactions, depression, or anxiety. These youth need support, and space to grow up prior to locking in lifelong medicalization of their gender identity, perhaps at the expense of not developing functional aspects, such as educational excellence, productive work skills, well-rounded leisure pursuits, and purpose and meaning through supportive communities. The availability of gender affirming care derails these developmental processes, and the sometimes difficult but necessary struggles that all teenagers face as they mature into adults.

CONCLUSION

190. It is a scientific and medical consensus that patients with gender dysphoria typically also have a mix of anxiety, depression, self-harm, personality disorders, neurodevelopmental disorders, and trauma-related symptoms. These mental health problems generally pre-date or co-occur with the development of gender dysphoria.

191. There is not a scientific or medical consensus that comorbid mental health disorders are due to "untreated" gender dysphoria, although this "minority stress" theory is frequently cited. The political nature of this minority stress claim goes along with the social justice ideology frequently expressed by advocates of gender affirming care.

192. These same advocates of affirming care claim that medical transition, and only medical transition, will resolve these youths' mental health problems. They claim that gender dysphoria in adolescents is eternally fixed and will not resolve. These theories do not have substantial supporting data.

193. When claims are made that there exists a scientific and medical consensus supporting gender affirming care for gender dysphoria, this rests on the assertions of a small group of physicians who are already personally invested in this type of care. Those already providing hormones and surgeries have extremely powerful reasons to want to believe affirmative care is ethical and effective.

194. When aligned with economic and ideological forces, a small group of physicians can wield disproportionate influence. The modern medical system does make serious mistakes at scale, and considering the many unknowns, physicians should be taking a cautious approach. Yet many physicians are unwilling to adopt a cautious approach, and thus legislative action is required.

195. Psychotherapy is a valid alternative mental health approach to medicalized treatments for gender dysphoria in youth. Existing psychotherapeutic approaches have already shown effectiveness treating anxiety, depression, self-harm, trauma reactions such as Post-Traumatic Stress Disorder and Borderline Personality Disorder, all which are frequent comorbidities. These established approaches could be augmented with more recently developed techniques, including mindfulness-based therapies, mind-body techniques, and specific exploratory therapies. Family therapy and support for parents should also become a mainstay of treatment. There is reason to suspect that psychotherapies can have better overall outcomes in treating gender dysphoria than medicalized approaches.

196. Shumer, Karasic and Turban all make predictions about harms that will come when these treatments are banned. In reality, a ban returns us to the situation that has existed all throughout human history, where human personal identity will develop into adulthood without chemical and surgical alteration of their secondary sex characteristics. Puberty blockers, hormones, and surgeries for youth are not medically necessary.

197. Many young people want more ability to express themselves as they please as it pertains to sexuality and gender expression. It is agreed that we need to create space for gender non-conforming individuals in our society. Yet that does not need to include medicalized treatments of gender dysphoria in youth. The context of this includes the recent overall rise in depression, anxiety, and self-harm. All this shows that we are not meeting the needs of our youth, and there are problems in our society and culture.

198. In the debate regarding treatments for gender dysphoria, the medical system should apply standard rules of evidence and proceed with caution. Whistleblowers in the United States (Reed 2022) and what has been revealed about gender clinics elsewhere (Barnes 2022) have made anyone paying attention realize we do need "Time to Think." It was a terrible mistake to roll out affirmative treatment for gender dysphoria via fiat from advocates, WPATH, and medical organizations without rigorous scholarly dialogue. Pausing treatment will give us that time to reconsider our medicalized approach to gender dysphoria in youth.

199. I declare under penalty of perjury under the laws of the United States that the foregoing is true and correct.

Executed this 26th day of May, 2023.

Kristopher E. Kaliebe, M.D.

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PUBLICATIONS

Kristopher Kaliebe, M.D.

Kaliebe, Kristopher and Adrian Sondheimer. "The media: Relationships to psychiatry and children." *Academic Psychiatry* 26.3 (2002): 205-215.

Kaliebe, Kristopher "Rules of thumb: three simple ideas for overcoming the complex problem of childhood obesity." *Journal of the American Academy of Child & Adolescent Psychiatry* 53.4 (2014): 385-387.

Kaliebe, Kristopher. "Dr Kaliebe Replies", Journal of the American Academy of Child & Adolescent Psychiatry, (2014) 53:10 1134.

Kaliebe, Kristopher "The Future of Psychiatric Collaboration in Federally Qualified Health Centers." *Psychiatric Services* (2016): appi-ps.

Kaliebe, Kristopher, and Josh Sanderson. "A Proposal for Postmodern Stress Disorder." The American journal of medicine 129.7 (2016): e79.

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Yeh, Y. Y. and **K. Kaliebe**. "Impact of Nutrition on Neurocognition." *Southern medical journal* 109.8 (2016): 454.

K. Kaliebe Expanding Our Reach: Integrating Child and Adolescent Psychiatry Into Primary Care at Federally Qualified Health Centers. J Am Acad Child Adolesc Psychiatry. 56.11 (2017)

Kiss, R. and **Kaliebe, K**., Stress and Inflammation: New Perspectives on Major Depressive Disorder. JAACAP Connect, p.22. Winter 2020

Tamburello, A., Penn, J., Negron-Muñoz, R., & **Kaliebe, K**. (2023). Prescribing Psychotropic Medications for Justice-Involved Juveniles. Journal of Correctional Health Care.

<u>Books, Textbook Chapters:</u>

Weigle, P., **Kaliebe, K**., Dalope, K., Asamoah, T., & Shafi, R. M. A. (2021). 18 Digital Media Use in Transitional-Age Youth: Challenges and Opportunities. Transition-Age Youth Mental Health Care: Bridging the Gap Between Pediatric and Adult Psychiatric Care, 357.

<u>Invited Publications</u>

"Telepsychiatry in Juvenile Justice Settings", **K Kaliebe**, J Heneghan, T Kim, Child and Adolescent Clinics of North America, 20 (2011) 113-123

American Academy of Child and Adolescent Psychiatry (AACAP) Committee on Telepsychiatry and AACAP Committee on Quality Issues. Clinical Update: Telepsychiatry With Children and Adolescents. J Am Acad Child Adolesc Psychiatry. 2017 Oct; 56(10):875-893. Epub 2017 Jul 25. PMID: 28942810.

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Gerwin, Roslyn L., **Kristopher Kaliebe,** and Monica Daigle. "The Interplay Between Digital Media Use and Development." Child and Adolescent Psychiatric Clinics 27.2 (2018): 345-355.

CURRICULUM VITAE

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Associate Professor
University of South Florida, Morsani College of Medicine, Tampa Florida

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3515 E. Fletcher Avenue, MDC 14
Tampa FL 33613
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kkaliebe@usf.edu

Citizenship

United States

Education

Graduate/Medical: St. George's University
School of Medicine, Grenada, West Indies
Medical Doctor — January 1995- June 1999

Undergraduate: Columbia College,
Columbia University
New York, NY,
Bachelor of Arts, Biochemistry — September 1988-May 1992

Postgraduate Training

Clinical Fellowships:
Fellow, Forensic Psychiatry (PGY6)
Louisiana State University Medical Center
1542 Tulane Ave., New Orleans, LA 70112 — July 2004 to June 2005

Fellow, Child and Adolescent Psychiatry (PGY 4-5)
Louisiana State University Medical Center
1542 Tulane Ave., New Orleans, LA 70112 — July 2002 to June 2004

Chief Resident in Child and Adolescent Psychiatry

- Acted as liaison between Child Psychiatry Fellows and Administration
- Coordinated with Program Director lecture and rotation schedules

July 2003 to June 2004

Residency:
Resident, Psychiatry (PGY 2-3)

University of Medicine and Dentistry-
New Jersey Medical School
185 S Orange Ave, Newark, NJ 07103 July 2000- June 2002

Internship: (PGY 1)
University of Medicine and Dentistry-
New Jersey Medical School
185 S Orange Ave, Newark, NJ 07103 July 1999- June 2000

Diplomate, American Board of Psychiatry and Neurology:

- Board Certification in General Psychiatry, awarded 2004, active
- Specialty Board Certification Child and Adolescent Psychiatry, awarded 2005, active
- Specialty Board Certification Forensic Psychiatry, awarded 2007, active

Awards, Honors, Honorary Society Memberships:

Department of Veterans Affairs Special Contribution Award for Clinical Service in Psychiatry
February 22, 2002

Outstanding Resident Award, Presented at the American Academy of Child and Adolescent Psychiatry, Miami, Florida,
October 17, 2003

Inducted into Berkeley Preparatory School Athletic Hall of Fame, Tampa, Florida,
November 7, 2003

Fellow, Louisiana State University Academy for the Advancement of Educational scholarship
October 2007 – 2016

Best Doctors, Louisiana in the subspecialty of Child and Adolescent Psychiatry
Awarded 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015 and 2016

Best Doctors, in Tampa Florida
2017, 2018, 2019, 2020, 2021, 2022

Awarded status as a Distinguished Fellow of the American Academy of Child and Adolescent Psychiatry

July 6, 2016

Appointments:

Associate Professor, University of South Florida Medical School, Department of Psychiatry. September 2016 to present

- Supervise one afternoon weekly of outpatient Child and Adolescent Psychiatry Silver Center Resident Clinic with USF General Psychiatry Residents and Child and Adolescent Psychiatry fellows who performed assessment, consultation, and treatment.
- Supervise one morning clinic of outpatient general psychiatry at the USF OPC Clinic who performed assessment, consultation, and treatment.
  - February 2023 to present

Tampa General Hospital Psychiatrist on Duty September 2016 to present

Manage the night, weekend and holiday clinical responsibilities of Tampa General Hospital including the over 1000 bed hospital and a 24-hour emergency room. Usually done in partnership with a psychiatric resident from the University of South Florida.

Facility Psychiatrist. Tampa Residential Facility September 2016 to present

- Performed psychiatric evaluations and treatment in Florida's juvenile correctional system. Tampa Residential Facility is the most intensive level of mental health and substance abuse treatment, subcontracted to Truecore Solutions.

Facility Psychiatrist. Les Peters Academy Residential Facility

May 2017 to present

- Performed psychiatric evaluations and treatment in Florida's juvenile correctional system, subcontracted to Truecore Solutions.

Staff Psychiatrist, Orleans Parish Justice System March 2018 to July 2018

- Performed telepsychiatric evaluations and treatment in Orleans Parish Prison correctional system, subcontracted to Correct Care Solutions.

Facility Psychiatrist. Charles Britt Academy Residential Facility

November 2019 to July 2022

•Performed psychiatric evaluations and treatment in Florida's juvenile correctional system, subcontracted by Sequel.

Facility Psychiatrist. Columbus Youth Academy Residential Facility

June 2020 to present

•Performed psychiatric evaluations and treatment in Florida's juvenile correctional system, subcontracted by Sequel.

Louisiana State University Health Science Center Assistant Professor of Clinical Psychiatry July 2005 to June 2017

Louisiana State University Health Science Center Associate Professor of Clinical Psychiatry July 2016 - 2017

Mental Health Medical Director, St. Charles Community Health Center, Luling, Louisiana July 2005 to 2016

- Evaluated and treated a primarily Medicaid and underserved population of adult, child and adolescent patients in a Federally Qualified Health Care Center.

Coordinator for Child and Adolescent Integrated Mental and Behavioral Health Services, Louisiana Mental and Behavioral Health Capacity Project

September 2012 to July 2017

- Performed assessment, consultation, training, prevention, and education services to Federally Qualified Health Centers and community clinics in Coastal Louisiana.
- Evaluated and treat both on site and using remote video conferencing equipment (telehealth).

Staff Psychiatrist, Back-up coverage, Louisiana Juvenile Justice System July 2016 to September 2022

- Performed psychiatric evaluations and treatment in Louisiana's juvenile correctional system, subcontracted to Wellpath (formerly Correct Care Solutions).
- Back up on call coverage for on-site psychiatrists
- As needed evaluated and treated remote video conferencing equipment (telehealth).

Staff Psychiatrist, Louisiana Juvenile Justice System July 2010 to July 2016

- Performed psychiatric evaluations and treatment in Louisiana's juvenile correctional system, subcontracted to Correct Care Solutions.
- Evaluated and treated both on site and using remote video conferencing equipment (telehealth).

Staff Psychiatrist on Duty October 2011 to July 2016
Children Hospital, Calhoun Campus. New Orleans, Louisiana

- Facilitated development of protocols and supervision regarding the training of Medical Students, General Psychiatry Residents and Child and Adolescent Psychiatric Fellows who utilize the Calhoun unit as primary training site for Child Psychiatry.
- Manage night and weekend clinical responsibilities for Children's Hospital emergency room and Inpatient Psychiatric Unit, including individually assessing all inpatients each weekend.

Staff Psychiatrist, Louisiana State University Juvenile Justice Program
July 2005 to August 2010

- Performed psychiatric evaluations and treatment in Louisiana's juvenile correctional system at Bridge City Center for Youth and Jetson Center for Youth.
- Evaluated and treated both on site and using remote video conferencing equipment (telehealth).

Staff Psychiatrist, Florida Parish Juvenile Detention Center,
July 2007 to August 2010

- Performed psychiatric evaluations and treatment using remote video conferencing equipment (telehealth).

Medical Officer on Duty July 2002 to July 2005
New Orleans Adolescent Hospital. New Orleans, Louisiana

- Managed clinical responsibilities of Crisis Intervention Services, a 24-hour emergency mental health response team serving families, children and adolescents from the Southeast Louisiana region.
- Managed two psychiatric inpatient units including a twenty bed adolescent and ten bed children's unit after hours on call.
- On call physician for Crisis Respite, a short term residential facility for children and adolescents located on hospital grounds.

Psychiatrist on Duty September 2003 to July 2005
New Orleans Veterans Administration Medical Center, New Orleans, Louisiana

- Managed clinical psychiatric responsibilities of a 450 bed hospital
- Managed clinical psychiatric responsibilities of a 27 bed inpatient psychiatric unit
- Managed clinical psychiatric responsibilities of 24-hour emergency room

Psychiatrist on Duty September 2001 to June 2002
New Jersey Medical Center Veterans Administration

- East Orange Medical Center, East Orange, NJ

Managed clinical psychiatric responsibilities of 24 hour emergency room along with a 295 bed hospital, 30 Nursing Home and 30 Domiciliary beds.

- Lyons Hospital, Lyons, NJ

Managed clinical psychiatric responsibilities of 356 bed hospital.

Teaching, Lecture

Undergraduate Medical Student

BMS6920.002, BMS6920.001 University of South Florida: Created five session elective: "Mind Body Medicine" Developed as part of University of South Florida medical school elective curriculum from 2017-2022. Offered for up to 12 students as a credited elective including study guide, organizing readings, and experiential class learning.
2017 to 2022

At Louisiana State University Health Science Center New Orleans:

4 one-hour lectures instructing all Medical Students (MS2) in Child and Adolescent mental health during Psychiatry Basic Science block

February 2004 to February 2016

LSU Physical therapy
Annual 2 two-hour lectures on a range of mental health topics annually

2012 to 2016

LSU Public Health
Annual 2 hour lecture on psychopharmacology to incoming Masters Level students in Public Health

2012 to 2016

Graduate Medical Teaching

MEL 8602 C65 M: Child and Adolescent Psychiatry

Child and Adolescent Psychiatry Resident Teaching:

Arranged and co-instructed Forensics Lecture Series, bi-annually 10 lecture hours and 4 hours of individual lectures.

2016 to present.

Teach various topics within residency training. 1 lecture per year.

2016 to present.

University of South Florida General Psychiatry Residency:

Co-Produced elective track for 2 residents per year within University of South Florida Psychiatry Residency. Supervision of Integrative Psychiatry residents within the University of South Florida's Integrative Psychiatry Track, biweekly sessions utilizing curriculum from the Andrew Weil Center for Integrative Medicine**.**

July 2020- present

Forensic Psychiatry Resident Teaching:

Teach child and corrections related forensic topics within residency training. 4 lectures per year.

2018 to present.

LSUHSC New Orleans, General Psychiatry Resident Teaching

- Created and taught one hour weekly (44 weeks per year) Cognitive Behavioral Therapy practicum for PGY 3 residents

  2007 to 2016
- One hour lecture on evolution and mood disorder each year for PGY3 residents

  2010 to 2016

LSUHSC New Orleans Child and Adolescent Psychiatry Resident Teaching

- One-hour didactic lectures on psychopharmacology for 8 weeks and cognitive behavior therapy for 4 weeks bi-annually

  2008-2016
- Organized and taught majority of the year-long bi-weekly one hour didactic program entitled Special Topics including a wide range of topics including development, forensic psychiatry, evolution, anthropology, nutrition, effects of technology, electronic media, sleep, exercise and physical activity, wellness and systems of care.

  2008 to 2016

LSU- Kenner Family Practice Residency:
Once yearly didactic lectures for 1 to 2 hours for Kenner Family Practice Residents

2009 to 2016

Created one session Mini-Course: "Optimizing Neurocognition through Nutrition." Developed and co-facilitated a module as part of Goldring Center for Culinary Medicine curriculum for medical students and other trainees with Annie Yeh, MD). Offered as a 1 credit elective for Tulane medical students including study guide, organizing readings, online webinar to be viewed prior to class, case studies during class and test.

2014

At Louisiana State University Health Science Center New Orleans: Core Clinical Psychiatry Rotation Lecture, 1 hour lecture presented to MS3 students every six weeks to 3rd year medical students covering Child Psychiatry Basics.

October 2003 to June 2005

At University of Medicine and Dentistry- New Jersey Medical School, Department of Psychiatry

• Lecture: "The Media and Psychiatry" for General Psychiatry Residents, created as part of the Culture and Psychiatry Seminar

August 2001 and 2002

Teaching, Supervisory

At University of South Florida, Tampa Florida:

Medical Student supervision

University of South Florida - 2017 to present
MEL 8109 L69 M
BCC 7154 002 M Psychiatry / Neurology Clerkship. Medical Students rotation through clinic one afternoon weekly of outpatient Child and Adolescent Psychiatry Silver Center Resident Clinic

Psychiatry Elective, 2 to 4 week Medical Student rotation through Child and Adolescent Psychiatry Silver Center Resident Clinic

Graduate Medical Education Supervision

Child and Adolescent Psychiatry Residency

Supervise one afternoon weekly of outpatient Child and Adolescent Psychiatry Silver Center Resident Clinic with USF Child and Adolescent Psychiatry residents who performed assessment, consultation, and treatment.
September 2016 to June 2021

Supervise one afternoon weekly of outpatient Child and Adolescent Psychiatry correctional psychiatry with USF Child and Adolescent Psychiatry residents who observe clinical care in juvenile correctional facilities.
September 2016 to present

General Psychiatry Residency:

Supervise one afternoon weekly of outpatient Child and Adolescent Psychiatry Silver Center Resident Clinic with USF General Psychiatry Residents who performed assessment, consultation, and treatment.
September 2016 to present

Forensic Psychiatry Resident Teaching

Supervision of forensic psychiatry trainees within the University of South Florida forensic psychiatry training program**.** This includes review of resident competency evaluations along with co-evaluation of criminal defendants as individual cases arise.
2018 to present

At Louisiana State University Health Science Center New Orleans

LSU- Kenner Family Practice Residency:

- One month, once weekly half day mental health rotation at St Charles Community Health Center for all Kenner Family Practice Residents
  2008 to 2016

Clerkship/Residency Directorship:

Child and Adolescent Psychiatry Fellowship Training Director, Louisiana State University Medical Center. Oversaw and supervised resident physician training Managed administrative, evaluation and scheduling issues within the training program Collaborated with Louisiana State University psychiatric faculty to develop policies and procedures at various clinical site.

July 2010 to September 2012

Teaching Awards:

Association for Academic Psychiatry Honorary Fellow

October 2001- October 2002

Louisiana State University Child and Adolescent Psychiatry Department Outstanding Teacher Award for the 2006-2007 academic year

Louisiana State University Child and Adolescent Psychiatry Department Outstanding Teacher Award for the 2015-2016 academic year

Peer to Peer: Institutional Grand Rounds

"The Minds, They are a Changin' – An Overview and Update on MDMA and Psilocybin Grand Rounds University of South Florida Psychiatry Department, Tampa Florida

January 28 2022

"3 Simple Rules for Overcoming Obesity" University of South Florida Endocrinology Department, Tampa Florida

November 9, 2021

"A hard pill to swallow: psychotropic medications in foster care", University of South Florida, Department of Public Health, Tampa Florida

November 3, 2017

"Rules of Thumb: The importance of heuristic and cognitive biases in pediatric physical and mental health" Grand Rounds Children's Hospital, New Orleans

July 30, 2014,

Grand Rounds, Louisiana State University Department of Psychiatry, "Rules of Thumb, lifestyle interventions for mental health professionals." New Orleans, Louisiana

January 23, 2014

"Just say No, the Case against Stimulant Medication" Grand Rounds Children's Hospital, New Orleans, Louisiana

May 19th, 2010

"Violence: Neurobiology, Risk Assessment and Beyond", Grand Rounds Louisiana State University Department of Psychiatry, New Orleans, Louisiana

August 9, 2012

"Is ADHD a Nutritional Disorder", Grand Rounds Louisiana State University Department of Psychiatry, New Orleans, Louisiana

July 28, 2011

"Just say No, the Case Against Stimulant Medication", Grand Rounds Louisiana State University Department of Psychiatry, New Orleans, Louisiana

July 29th, 2010

Grand Rounds Department of Psychiatry, Louisiana State University School of Medicine, New Orleans, Louisiana "The Application of Darwinian Principles to Child Custody Evaluations", New Orleans, Louisiana

May 26th, 2005

"Attention Deficit Hyperactivity Disorder" Grand Rounds Department of Pediatrics, Louisiana State University School of Medicine, New Orleans, Louisiana

May 25th, 2005

"The Media, Our New Social World, How Should Pediatricians Respond?" Grand Rounds, Louisiana State University School of Medicine, Children's Hospital, New Orleans, Louisiana

June 2nd, 2004

"Attention Deficit Disorder" for Louisiana State University Health Science Center Juvenile Corrections Program Continuing Medical Education Presentation via telemedicine New Orleans, Louisiana

March 16th, 2004

"The Media, Relationships to Children and Psychiatry", Grand Rounds, Department of Psychiatry, Louisiana State University School of Medicine, New Orleans, Louisiana

June 4th, 2003

"The Media, Relationships to Children and Psychiatry", Grand Rounds, New Orleans Adolescent Hospital, New Orleans, Louisiana

March 28th 2003

Lectures by Invitation

"The Media, Relationships to Children and Psychiatry" Grand Rounds, University of West Virginia, Charleston, West Virginia, Department of Psychiatry and Behavioral Science

April 10th 2003

"The Media and Child and Adolescent Psychiatry –An Evolving Relationship" Chair and Presenter, Media Theatre, Annual Conference of the American Academy of Child and Adolescent Psychiatry

October 21st, 2004

"The Media, Our New Social World, How Should Health Care Professionals Respond?" Continuing Medical Education Presentation Snowshoe Mountain Retreat, Snowshoe Mountain, West Virginia

September 19th, 2004

"The Application of Darwinian Principles to Child Custody Evaluations" Grand Rounds Department of Psychiatry, University of South Florida, Tampa, Florida

October 31st, 2005

"The Evaluation and Treatment of Traumatized Children and Adolescents with ADHD" Web Cast Presentation and Grand Rounds sponsored by the National Center for Child Traumatic Stress Network's Rural Consortium, New Orleans, Louisiana

January 25th, 2007

"Behavioral Disorder or Traumatized Child?" Louisiana Federation of Families for Children's Mental Health, Children's Mental Health Conference, Houma Louisiana

May 9th, 2008

"Behavioral Disorder or Traumatized Child?" Grand Rounds Tulane University Department of Child Psychiatry, New Orleans, Louisiana

March 13th, 2009

"Brother's Little Helper: The Simpsons Satirizes Stimulant Medication as a Response to Childhood Behavior Problems" Media Theatre, Annual meeting of the American Academy of Child and Adolescent Psychiatry, New York, New York Kristopher Kaliebe MD, K. Dalope, MD

October 30, 2010

"Violence Risk Assessment" Louisiana Psychiatric Medical Association Annual Meeting, New Orleans, LA

March 2, 2013,

"Telepsychiatry in Juvenile Justice Settings" part of "Telepsychiatry: Challenges and Successes Across Settings." Clinical Perspectives, Annual meeting of the American Academy of Child and Adolescent Psychiatry, Orlando FL

October 22, 2013

"What are they Missing, When Electronic Media Displaces Sleep, Academics and Exercise" part of "Identifying and Treating Internet-Related Mental Health Problems:

An Evidence-Based Approach" Clinical Perspectives. Annual meeting of the American Academy of Child and Adolescent Psychiatry, Toronto, Canada
October 24, 2014

"The Implications of the Pharmacological Treatment of Children" Michigan Drug Court Annual Conference, Lansing, Michigan
March 12, 2014

"Three rules to prevent and treat ADHD symptoms" as part of the Louisiana ADHD Symposium, organized by the Louisiana Department of Health and Hospitals ADHD Task Force, Baton Rouge, Louisiana
December 9, 2014

"Non-Pharmaceutical Interventions for ADHD", Invited Professorship: St George's University School of Medicine Complementary and Alternative Medicine Selective, St George's, Grenada, West Indies
August 28 – Sept. 3rd, 2014

"Screen Time and Childhood Behavior: Disruptive Influence or Easy Scapegoat" as part of "Caught in the Net, How Electronics effects Mental Illness" Chair and Presenter, Clinical Perspectives, Annual meeting of the American Academy of Child and Adolescent Psychiatry, San Diego, California
October 30, 2014

"The Management of Childhood Obesity" and "Disordered Eating in Children and Adolescents" Oregon Psychiatric Medical Association Conference, Portland, Oregon
February 27 and 28, 2015

"Rules of Thumb: 3 Simple Rules to Optimize Physical and Mental Health" National Alliance for the Mentally Ill Louisiana Annual Conference, New Orleans, Louisiana
April 17, 2015

"ADHD overdiagnosis in Louisiana, a child and adolescent psychiatrist's perspective" Preventing Overdiagnosis Conference, National Institutes of Health (NIH), Bethesda Maryland
September 2, 2015

"An alternative to diagnosis-based practice in pediatric mental health" Preventing Overdiagnosis Conference: National Institutes of Health NIH Bethesda Maryland
September 2, 2015

"Shell Shocked: Growing up in the Murder Capital of America". Discussant for Media Theatre, Annual meeting of the American Academy of Child and Adolescent Psychiatry, Holly Peek, MD, Kristopher Kaliebe, MD San Antonio, Texas
October 29, 2015

"Screen Time and Childhood Behavior: Disruptive Influence or Easy Scapegoat" as part of "Caught in the Net, How Electronics effects Mental Illness" Chair and Presenter, Clinical Perspectives, Annual meeting of the American Academy of Child and Adolescent Psychiatry, San Antonio, Texas

October 31, 2015

"What are they (we) Missing? When Electronic Media Displaces Sleep, Academics, and Exercise" Grand Rounds University of South Florida Psychiatry Department, Tampa Florida

November 12th, 2015

ADHD overdiagnosis in Louisiana, a child and adolescent psychiatrist's perspective, Louisiana Psychological Association, New Orleans, LA

May 20, 2016

"Rules of Thumb: 3 Simple Rules to Optimize Physical and Mental Health" Crohns and Colitis Association of America Regional Conference, New Orleans, LA,

June 12, 2016

"Evaluating and Assuring the Effective and Safe Use of Psychotropic Medications in Children" Webinar: National Council of Juvenile and Family Court Judges, with Judge Constance Cohen; Janie Huddleston and Dr. Joy Osofsky, Ph.D.

June 24, 2016,

"Psychotropic Medications 101: What Judges Need to Know for Effective Decision Making" Florida Child Protection Summit, with Melinda Sczepanski, Orlando FL

September 9, 2016

"Communicating With the Media and the Public as Child and Adolescent Psychiatrists Around Disaster and Highly Traumatic Events." Workshop, Annual meeting of the American Academy of Child and Adolescent Psychiatry, Media Training Workshop, New York, New York

October 27, 2016

"Evolutionary Biology is a Basic Science for Child and Adolescent Psychiatry" Special Interest Group, Annual meeting of the American Academy of Child and Adolescent Psychiatry, New York, New York

October 28, 2016

"Is War Ever Really Over? War-Affected Youth From Home to Host Country", Discussant, Clinical Perspectives. Annual meeting of the American Academy of Child and Adolescent Psychiatry, New York, New York

October 28, 2016

"Psychotropic Medications 101: The pertinent essentials for all involved in the child welfare system" Florida Child Protection Summit, with Melinda Sczepanski, Orlando, Florida

August 30, 2017

"Safe Use of Psychotropic Medications in Children." 2017 Safe Babies Court Teams Cross Sites Meeting, Fort Lauderdale, Florida

August 17, 2017

"Health Promotion in Pediatric Mental Health" Discussant, Clinical Perspectives, Annual meeting of the American Academy of Child and Adolescent Psychiatry, Washington, DC

October 23, 2017

"New Technologies, New Laws, New Childhood" as part of "Clinical Guidelines for Navigating Media Use" Clinical Perspectives, Annual meeting of the American Academy of Child and Adolescent Psychiatry, Washington, DC

October 24, 2017

"Screen Time and Childhood Behavior: Disruptive Influence or Easy Scapegoat" as part of "Caught in the Net, How Electronics effects Mental Illness" Chair and Presenter, Clinical Perspectives, Annual meeting of the American Academy of Child and Adolescent Psychiatry, Washington, DC

October 26, 2017

"The Business of News, the Role of Child and Adolescent Psychiatrists in the Media, and Risk Communication." Member Services Forum, Annual meeting of the American Academy of Child and Adolescent Psychiatry: Washington, DC

October 27, 2017

"Caught in the net: a child psychiatrist's guide for navigating the internet age.", Workshop, International Association for Child and Adolescent Psychiatry and Allied Professions, Prague, Czechoslovakia

July 27, 2018

Chair, Clinical Perspectives, Annual meeting of the American Academy of Child and Adolescent Psychiatry, "Caught in the Net: How Digital Media Shapes Mental Illnesses in Youth and How Psychiatrists Should Respond." Seattle, Washington

October 24, 2018

"Self-Care in the Child Welfare System" YMCA/Safe Children Coalition Conference, with Catarlyn Glenn, Sarasota Florida

April 18, 2019

"Psychotropic Medications 101: The pertinent essentials for all involved in the child welfare system" Florida Child Protection Summit, with Catarlyn Glenn, Orlando Florida

December 17, 2019

"Caught in the Net: How Digital Media Interacts with Mental Illness in Children and Adolescents", Annual Conference of the Florida Psychiatric Society, Tampa, Florida
September 21, 2019

"Effective Strategies for Higher Education and Beyond" Clinical Perspectives, Annual meeting of the American Academy of Child and Adolescent Psychiatry, Mastering Information Flow for Transitional-Age Youth (TAY): as part of "Promoting Digital Citizenship in Transitional-Aged Youth (TAY) and College Students", Chicago, IL
October 19, 2019

"Caught in the Net: How Digital Media Interacts with Mental Illness", virtually presented at the Andrew Weil Center for Integrative Medicine, Tucson, Arizona
April 1, 2020

"A deeper dive into child and adolescent psychopharmacology for families and professionals involved in the child welfare system" Florida Child Protection Summit, with Catarlyn Glenn. Orlando, FL
September 3, 2020

"Screenagers: Next Chapter – How Online Behaviors Affect Depression and Anxiety Disorders in Adolescents", Media Theater (virtual) Annual meeting of the American Academy of Child and Adolescent Psychiatry
October 19, 2020.

"Helping Child Psychiatrists Navigate the Internet Age", "Career Focus: Setup Your Own Telepsychiatry Practice", "COVID-19 Related Psychiatric Issues"
Oasis Child and Adolescent Psychiatry Conference, Charleston, SC
May 17, 2021

"Conversation about health information, COVID, news, and related topics", discussant and breakout group leader, Digital Media and Mental Health Research Virtual Retreat
May 24th 2021

"The Social Dilemma: Helping Families Navigate the Pull, Pulse, and Power of Social Media", Media Theater, Annual meeting of the American Academy of Child and Adolescent Psychiatry, Virtual
October 29, 2021

"Appealing Applications for Adolescent Mental Health: Social Media's Transformation During the COVID-19 Pandemic", Discussant, Clinical Perspective, Annual meeting of the American Academy of Child and Adolescent Psychiatry, Virtual
October 25, 2021

"Angry Young Men, Common Threads in Different Types of Extremist Groups" as part of Political Extremism & Hate Group Recruitment of Adolescents", Clinical Perspective, Annual meeting of the American Academy of Child and Adolescent Psychiatry, Virtual
October 26, 2021

"Angry Young Men: Boys and Adolescent Males with Disruptive and Aggressive Behavior", "Nutritional Child Psychiatry" Oasis Child and Adolescent Psychiatry Conference, Charleston, SC
May 1st / 2nd, 2022

"Sexts, Lies & Videogames: Adolescent Boys, the Internet, & Mental Health" Chair and presenter on violence and young men: Clinical Perspective, Annual Meeting of the American Academy of Psychiatry Annual Meeting, New Orleans, LA
May 25, 2022

"Assessing and Addressing Digital Distraction, Misinformation, and Disarray", part of the Social Media Institute, Annual Meeting of the American Academy of Psychiatry Annual Meeting, Toronto, CA October 19, 2022

Licensure:

Florida Medical License, expires January 31st, 2024

Federal DEA Controlled Substances License 12/31/2023

Certification: ECFMG Certificate 0-573-532-9

Forensic Training:

Florida Forensic Examiner Training completed through the University of South Florida Department of Mental Health Law and Policy
August 15-17, 2019

Certifications in Psychotherapy:

Basic Practicum in Rational Emotive Behavior Therapy completed at the Albert Ellis Institute in New York, NY
July 13, 2003

Advanced Practicum in Rational Emotive Behavior Therapy completed at the Albert Ellis Institute in New York, NY
July 20, 2003

Associate Fellowship in Rational Emotive Behavior Therapy completed at the Albert Ellis Institute in New York, NY,
July 15, 2005

Accelerated Resolution Therapy, Basic Training
April 1-3, 2017

Accelerated Resolution Therapy, Enhanced Training
Sept 31, October 1, 2018

Accelerated Resolution Therapy, Advanced Training
October 2,3, 2018

American Association of Medical Colleges Medical Education Research Certificate
October 13th, 2010

Scholarly Activity

Funded block grants

Co-investigator on the Mental and Behavioral Health Capacity Project from September 2012 to June 2017

Unfunded research

Supervisor mentoring Medical Students:

University of South Florida IRB: Faculty Advisor Co Investigator May 2021

What is the impact of coronavirus confinement on Japanese college students' mental health? STUDY002335

University of South Florida IRB: Faculty Advisor Co Investigator May 2021
Changes in college aged students' metabolic health due to Covid-19 confinement STUDY002341

PI as student supervisor, STUDY004118, IRB approved as Exempt Status, Palliative Care Patients' Attitudes & Openness to Psilocybin assisted Psychotherapy for Treatment of Existential Distress, Julia Wang

Journal Publications:

Peer Reviewed

Kaliebe, Kristopher and Adrian Sondheimer. "The media: Relationships to psychiatry and children." *Academic Psychiatry* 26.3 (2002): 205-215.

Kaliebe, Kristopher "Rules of thumb: three simple ideas for overcoming the complex problem of childhood obesity." *Journal of the American Academy of Child & Adolescent Psychiatry* 53.4 (2014): 385-387.

Kaliebe, Kristopher. "Dr Kaliebe Replies", Journal of the American Academy of Child & Adolescent Psychiatry, (2014) 53:10 1134.

Kaliebe, Kristopher "The Future of Psychiatric Collaboration in Federally Qualified Health Centers." *Psychiatric Services* (2016): appi-ps.

Kaliebe, Kristopher, and Josh Sanderson. "A Proposal for Postmodern Stress Disorder." The American journal of medicine 129.7 (2016): e79.

Osofsky, Howard J., Anthony Speier, Tonya Cross Hansel, John H. Wells II, **Kristopher E. Kaliebe**, and Nicole J. Savage. "Collaborative Health Care and Emerging Trends in a Community-Based Psychiatry Residency Model." *Academic Psychiatry* (2016): 1-8.

Yeh, Y. Y. and **K. Kaliebe**. "Impact of Nutrition on Neurocognition." *Southern medical journal* 109.8 (2016): 454.

K. Kaliebe Expanding Our Reach: Integrating Child and Adolescent Psychiatry Into Primary Care at Federally Qualified Health Centers. J Am Acad Child Adolesc Psychiatry. 56.11 (2017)

Kass, R. and **Kaliebe, K**., Stress and Inflammation: New Perspectives on Major Depressive Disorder. JAACAP Connect, p.22. Winter 2020

Tamburello, A., Penn, J., Negron-Muñoz, R., & **Kaliebe, K**. (2023). Prescribing Psychotropic Medications for Justice-Involved Juveniles. Journal of Correctional Health Care.

Case Reports, Technical Notes, Letters

Books, Textbook Chapters:

Weigle, P., Kaliebe, K., Dalope, K., Asamoah, T., & Shafi, R. M. A. (2021). 18 Digital Media Use in Transitional-Age Youth: Challenges and Opportunities. Transition-Age Youth Mental Health Care: Bridging the Gap Between Pediatric and Adult Psychiatric Care, 357.

Invited Publications

"Telepsychiatry in Juvenile Justice Settings", **K Kaliebe**, J Heneghan, T Kim, Child and Adolescent Clinics of North America, 20 (2011) 113-123

American Academy of Child and Adolescent Psychiatry (AACAP) Committee on Telepsychiatry and AACAP Committee on Quality Issues. Clinical Update: Telepsychiatry With Children and Adolescents. J Am Acad Child Adolesc Psychiatry. 2017 Oct; 56(10):875-893. Epub 2017 Jul 25. PMID: 28942810.

Kaliebe, Kristopher and Paul Weigle. "Child Psychiatry in the Age of the Internet." (2017). Child and Adolescent Psychiatric Clinics of North America, April 2018Volume 27, Issue 2, Pages xiii–xv

Gerwin, Roslyn L., **Kristopher Kaliebe,** and Monica Daigle. "The Interplay Between Digital Media Use and Development." Child and Adolescent Psychiatric Clinics 27.2 (2018): 345-355.

Other Research and Creative Achievements:

Poster Presentations:

"Collaborative Child and Adolescent Psychiatry within Primary Care Clinics in Coastal Louisiana" Poster, Annual meeting of the American Academy of Child and Adolescent Psychiatry, **Kristopher Kaliebe MD**, Joy Osofsky, PhD; Howard Osofsky, MD, PhD; Lucy King, BA; Tonya Hansel, PhD, San Antonio, TX
October 29, 2015

"Benefits of Integrating Young Child Psychiatric Services Into Primary Care Clinics in Underserved Communities" Poster, Annual meeting of the American Academy of Child and Adolescent Psychiatry, New York, NY Joy Osofsky, PhD; Howard Osofsky, MD, PhD; Lucy King, BA; Tonya Hansel, PhD, **Kristopher Kaliebe MD**
October 28, 2016

"Integrating child and adolescent psychiatry into community based primary care networks", Poster, International Association for Child and Adolescent Psychiatry and Allied Professions, Prague, Czechoslovakia **Kristopher Kaliebe MD**
July 25, 2018

" The Prevalence of the Adverse Childhood Experiences (ACE) in Florida Youth Referred to the Department of Juvenile Justice" Poster, Annual meeting of the American Academy of Psychiatry and the Law, Greg Iannuzzi, MD, Mark Greenwald, PhD**, Kristopher Kaliebe MD**
October 25, 2018

Other articles:

"LSU's *Breakfast Club* emphasizes education and recruitment into Child and Adolescent Psychiatry", American Academy of Child and Adolescent Psychiatry News,
January 2004
"Trix are for Kids!", American Academy of Child and Adolescent Psychiatry News,
May, 2013
Expanded Psychiatric Care Can Transform Federally Qualified Health Centers, American Psychiatric Association News,
..... Published online June 17, 2016

News Stories on Suicide, Fictional Content may Increase Risk for Contagion, Hansa Bhargava and **Kristopher Kaliebe**, American Academy of Pediatrics News, *Mastering the Media Column*,

Published online July 10, 2019

Webinars and creation of enduring materials:

Rules for Optimal Health, Webinar, University of South Florida Quality Parenting Initiative, Florida's Center for Child Welfare Information and Training Resources for Child Welfare Professionals, released

..... December 11, 2017

Florida's Center for Child Welfare Information and Training Resources, webinars series on pediatric mental health for child welfare professionals and caregivers, Kristopher Kaliebe with Catarolyn Johnson;

..... June 1, 8, 15, 22 and 29, 2020

"Don't just sit there- Adapt and Optimize in a post Covid world" University of South Florida Global Health Conversation Series, presented virtually

September 22, 2020

Service

Membership in Professional Organizations:

Member, American Academy of Child and Adolescent Psychiatry (AACAP),

2000 to present

AACAP Media Committee member

2003 –2021

C0-Chair, AACAP Media Committee

2013-2021

Media Committee Liaison to the Complementary and Integrative Medicine Committee of the AACAP

2012 to 2019

Liaison to the Committee on Communications and Media of the American Academy of Pediatrics, from American Academy of Child and Adolescent Psychiatry (AACAP)

2015 to 2022

Member Association for Behavioral and Cognitive Therapies

2004 – 2016

Member American Academy of Psychiatry and the Law
2004 to present

Member Zero to Three
2017 to 2021

Member Louisiana Council for Child Psychiatry (LCCP)
2003 to 2016

Louisiana Council for Child Psychiatry (LCCP)

Secretary-Treasurer
March 2010-March 2014

President
March 2014- June 2016

Member, American Psychiatric Association
2000 - 2012 , 2021 to present

LSUHSC Psychiatry Interest Group Faculty advisor
2008 to 2012

University of South Florida Medical School Integrative Medicine Student Interest Group faculty advisor
January 2020 to present

University of South Florida Medical School Mindfulness and Meditation in Medicine Group faculty advisor
January 2022 to present

University of South Florida Interdisciplinary (university wide) Psychedelics Interest Group faculty advisor
March 2022 to March 2023

Editorial Posts and Activities:
Journal editorships, Reviewer

LSUHSC Institutional Review Board alternate reviewer 2008-2012

Safety Committee Member, Accelerated Resolution Therapy for Treatment of Complicated Grief in Senior Adults, University of South Florida
2017-19

Expert reviewer for *Adolescent Psychiatry* Thematic Special Issue: Coming of Age Online: Challenges of Treating the Internet Generation: (2), 4, 2014

Expert reviewer for *Academic Psychiatry* Media Column June 2018

Expert Reviewer for *Pediatrics* January 2021

Expert reviewer for *Academic Psychiatry* Media Column March 2022

Expert Reviewer for *Harvard Review of Psychiatry* May 2021

Co-editor: Kaliebe, Kristopher, and Paul Weigle. Youth Internet Habits and Mental Health, An Issue of Child and Adolescent Psychiatric Clinics of North America, E-Book. Vol. 27. No. 2. Elsevier Health Sciences. 2018

Member, Planning Committee for the Digital Media and Mental Health Research Retreat hosted by the nonprofit Children and Screens.
May 24th, 25th 2021.

Revised: March 2023